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Mentally Ill Offender Systems in the Western States

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Mentally Ill Offender Systems in the Western States

Compiled and Edited by

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Western Interstate Commission for Higher Education

WICHE

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The WICHE Mental Health and Human Services Program is pleased to present this publication, Mentally Ill Offender Systems in Western States. The publication contains proceedings of the conference "The Mentally Ill Offender: Problems and Issues Facing Mental Health and Corrections Systems in the West" held in Albuquerque, May 22-23, 1982. It also contains results of a survey of forensic hospitals in the thirteen western states conducted by WICHE in March and April 1983.

The interstate mentally ill offender conference of decision makers in mental health and criminal justice systems was organized at the suggestion of the Western States' Mental Health Manpower Coordinating Council, the interstate advisory group to the WICHE Mental Health Program. The council, which represents state mental health manpower development programs in the thirteen western states established the framework for the conference and suggested programs to be presented there. We wish to thank the coordinating council members and staff of the New Mexico Mental Health Human Resource Development Program for their assistance in organizing and conducting the conference.

We also wish to thank the individuals who presented their programs to the conference and who subsequently provided summaries of their presentations for this publication.

The cooperation of state mental health agencies and directors of forensic programs in responding to the survey of forensic hospitals was outstanding. We appreciate the many hours they spent in collecting data and participating in the hour-long telephone interview. We are impressed by the calibre of leadership in forensic programs in our states and grateful for their generosity in sharing information on issues and problems in their systems.

Appreciation is also due to many individuals on the WICHE staff who participated in preparation of the publication: Paul Albright and Karen Fisher for editing and formatting the publication; Edith Modafferi for typing and preparation for printing; and Marie Sanchez for organization of the conference and overall supervision of the publication.

Meredith Davis, A.C.S.W.
Editor

INTRODUCTION

When a Washington, D.C., jury found John Hinckley not guilty by reason of insanity of shooting the president and members of his staff, federal and state systems for dealing with the mentally ill offenders were thrust once more onto the front pages of newspapers throughout the country. Some sixty-six proposed laws to eliminate or change the federal law regarding the insanity defense were introduced in the United States Congress. Similar action on the part of state legislators is occurring in many, if not most, of the fifty state legislatures.

Unfortunately, it appears that most of this activity is concentrated on the wrong problem with over-simplistic solutions. A recent conference of western state leaders in corrections and mental health concluded that, at least in the western states, the insanity defense is little used and that the number of individuals found not guilty by reason of insanity is a very small proportion of the mentally ill offender (MIO) population dealt with by the corrections and mental health systems. On the other hand, evaluation, treatment, and aftercare of persons referred by the courts as incompetent to stand trial; persons in prisons and jails with psychoses and other serious mental health problems; and civilly committed and voluntary hospital patients who are dangerous and in need of treatment in a secure facility are growing problems in need of attention.

Insanity Defense Laws Are Not the Problem

A national survey (Steadman and Braff, 1981, p. 35) of "mentally disordered offenders" adjudicated and confined in various institutions in 1978 reveals that of 20,143 adjudicated persons in the various state and federal forensic facilities, only 8.1 percent were insanity acquittals. The remainder were persons found incompetent to stand trial, transfers from prisons, or disordered sex offenders.

The recent conference sponsored by the Western Interstate Commission for Higher Education illustrated that the insanity defense is used rarely and succeeds infrequently in western states. New Mexico, for example, has an average of less than one person per year who prevails with the insanity defense; Wyoming records one success per eighty attempts; Idaho has twelve to fifteen successful insanity pleas per year; Hawaii fewer than thirty.

Oregon reports the highest use of the insanity defense--about 100 per year, or .1 percent of the criminal cases in the state. Of these, 79 percent of 359 persons in Oregon were found "not responsible" in uncontested hearings and 18 percent in contested trials before a judge; only 3 percent went to a jury trial.

Criminal Commitments Are Increasing

Some indication of the increasing numbers of mentally ill offenders impacting the systems in western states include the following:

- In Hawaii, the number of penal admissions to the state hospital increased from eighteen in 1974 to 186 in 1980. During the last six years (1976 through 1981) penal code admissions to the state hospital increased from 5 percent of total patients admitted to 28 percent. The number of misdemeanor penal admissions increased from 10 percent of all penal code admissions in 1975 to 68 percent in 1979 and 60 percent in 1980.

- In Oregon, the number of admissions to forensic psychiatric service of persons not guilty of crime by reason of mental disease or defect increased from twelve in 1970 to 116 in 1979 and seems to have leveled off since then. The number of misdemeanants in that population rose from 19 percent in 1978 to 31 percent in 1980.

- In New Mexico, an additional thirty-bed ward was opened in 1981 to care for transfers of mentally ill persons from the state prison.

- In Nevada, the number of persons found not competent to stand trial increased from sixty-eight in 1977 to ninety-eight in 1980.

It is not clear whether this increasing demand for services is due to a true increase in the number of MIOs, a recycling of the mentally ill formerly handled by the civil system into the criminal system, or better identification of formerly undiagnosed mentally ill persons in the criminal population.

There are indications that many of the individuals released from state hospitals to communities with few services to meet their needs may be showing up in the jails and court systems. A recent article (Shah, 1981, p. 229) pointed out that tightened standards and procedures controlling civil commitments may have resulted in greater use (and possible misuse) of the criminal, conservatorship, and guardianship processes to seek hospitalization and treatment of seriously mentally ill but nondangerous persons.

One of the presenters at the WICHE conference likened the process to a balloon which if squeezed in a certain way may result in patients being committed through the civil process but if this avenue is closed may move the commitment through the criminal process. Recent changes in most civil commitment procedures requiring proof of dangerousness or grave disablement in forty-six of the fifty states has substantially reduced the number of patients civilly committed to state hospitals, while criminal commitments are increasing.

Problems of Agency Coordination

In addition to the pressures of increasing numbers of mentally ill offenders, the number and variety of agencies and personnel who are involved in decisions regarding evaluation, disposition, treatment, release, and aftercare of offenders make it difficult to organize an effective, smoothly functioning overall system in the states. Those who may be involved with a single client include police and sheriffs, jail personnel, judges, prosecuting and defense attorneys, probation and parole officers, mental health evaluation teams or professionals, state hospital or corrections forensic hospitals, mental health centers and private psychiatric practitioners, and specialized mental health or correctional facilities and programs. Differing philosophical and value orientations and differing system objectives between legal and mental health systems and personnel complicate the development of an approach to the problem which is satisfactory to the various agencies and effective for the MIO. Strong adversarial and antagonistic relationships between mental health and corrections personnel often develop. The public at large continues to be most concerned that mentally ill offenders not "get off" because of the determination of mental illness and thereby avoid punishment.

Problems of Fiscal and Staffing Resources

Mental health and corrections agencies face problems of insufficient funds and too few staff trained to provide appropriate treatment for offenders in hospitals, prisons and jails, and aftercare in community settings. While coordination of mental health and corrections programs and selection of cost-effective methods of evaluation and treatment can help in making better use of current resources, additional resources for treatment and staff training are crucial if substantial improvement in systems of care are to be attained. The recent report of the National Commission on the Insanity Defense, Myths and Realities (1983), notes the following:

> No amount of tinkering with the insanity defense or manipulation of the verdicts in criminal cases will relieve legislators of their responsibility to appropriate the dollars necessary to provide humane and beneficial care to mentally ill offenders. (p. 42)

WICHE Conference on the Mentally Ill Offender

In response to concerns expressed by the Western States' Mental Health Manpower Coordinating Council about the increasing demands for services, community pressures to eliminate or restrict the insanity defense and the need to improve the quality of services within resource limitations, the Western Interstate Commission for Higher Education conducted a conference on "The Mentally Ill Offender: Problems and Issues Facing Mental Health and Corrections Systems in the West" in Albuquerque on May 22-23, 1982. The WICHE conference brought together decision makers in mental health and criminal justice systems from the thirteen western states to share information on issues and programs necessary to build more effective systems of care for mentally ill offenders. Models for providing the different components of a comprehensive MIO system were presented and discussed. Components of a

comprehensive system of care which were addressed included:

- Planning for forensic services
- Coordinating the system
- Pre-trial forensic evaluation and treatment
- Supervision of insanity defense offenders
- Treatment considerations in forensic hospitals, prisons, and community facilities and
- Legal issues affecting treatment

As discussions of different models for providing services developed, it became apparent that several factors affect the feasibility and viability of incorporating new models into a state's system. These factors include the wide variation among the states in how systems are organized; which agencies are responsible for different aspects of the system; and laws, policies, funding patterns, and history of service provision. It also became apparent that effective planning and program development in the states is hampered by a lack of comparable information from the different states on numbers and types of clients served, costs of different programs, staffing patterns, and the effectiveness of different approaches. In order to assess the viability of transfer of programs found effective in one state to other states, participants requested WICHE to provide copies of papers presented at the conference and to compile and distribute information on statistics, laws, and systems of care in the thirteen western states. This publication responds to these recommendations.

Organization of the Publication

Section I provides a summary of conference proceedings. Dr. Bloom's keynote address provides an overview of the involvement of mentally ill patients in the criminal justice system and the comprehensive system Oregon has developed to respond to problems identified in the literature. Shah's paper addresses specific aspects of planning for forensic services. Blaylock presents the model Hawaii has developed to coordinate planning, program development, and service provision among institutional and community corrections and mental health agencies and personnel. Tennessee's community-based system for pretrial forensic evaluation and treatment is described by Whitlock, and Oregon's system for ongoing supervision and treatment of insanity defense offenders is the subject of Rogers' paper. Presentations and summaries of small group discussions are presented in the chapter "Treatment Considerations in Hospitals, Prisons, and Community Facilities." Muxlow discusses legal problems in implementing applicable court decisions in the mental health area for prisoners. Section I concludes with Shah's summary of the conference discussion and recommendations.

Section II provides results of a survey of forensic hospitals in the thirteen western states conducted by WICHE subsequent to the conference. The section provides a series of tables listing data by state and discussion of the data presented. This is followed by a brief description of each state's system for dealing with MIOs, recent legislation or procedural changes affecting the system and the most significant problems currently facing forensic administrators.

Conclusion

Mental health services for the offender population--how services should be organized, what offenders should be served where and by whom, what types of services are most effective and efficient, what level of resources should be devoted to this population--will, no doubt, be a priority concern for state legislatures, governors, and mental health and corrections agencies for some years to come. Appropriate planning to build more effective systems of care requires research on use and operation of the insanity defense, evaluation of the effectiveness of different approaches to evaluation and treatment, and identification and sharing of effective programs among the states. The lack of data and, even, descriptive information on state programs and systems make it difficult for state administrators to plan and develop programs that are responsive to the fears and concerns of the public at large and, at the same time, meet the needs of the offender population for mental health services.

This publication is a first step toward sharing information about mentally ill offender systems among the western states. We hope it will be helpful to administrators and that WICHE may have the opportunity to continue to work with state decision makers in this important field.

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SECTION I

SUMMARY OF CONFERENCE PROCEEDINGS

Keynote Address

BUILDING A STATEWIDE SYSTEM FOR THE MENTALLY ILL OFFENDER

by

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Editor's Note: Dr. Bloom's presentation on "Building a Statewide System for the Mentally Ill Offender" provides us with an overview of the involvement of mentally ill patients in the criminal justice system. We are given a look at developing literature on arrests of mental patients, a review of empirical data on the insanity defense, a review of recent data on mentally ill persons in prisons and jails, and a very brief look at the recently developing literature on the young chronically mentally ill patient. All of this literature and data begin to tie together some of the issues that are raised when we look at mentally ill people who are arrested, who succeed in an insanity defense, or who are imprisoned.

The involvement of psychiatric patients in the criminal justice system has come under increasing attention within the past six years. Research conducted by Zitrin et al. (1976) in New York City, by Durbin et al. (1977) in Wyoming, and by Sosowsky (1978) in San Mateo County in northern California, all demonstrate clearly that mental patients are arrested more frequently than non-mentally ill persons in these three distinctly different regions of the country. That mentally ill persons, or certain groups of mentally ill individuals, are arrested more frequently than the average person, seems now to be accepted.

Two major hypotheses have been put forward to explain the increased arrest rates of mental patients. Steadman et al. (1978) found that there are more criminals in mental hospitals and this accounts for the increased arrest rates. Grunberg and associates (1977; 1978) suggested "that more liberty for the traditional hospital patient is likely a crucial factor in explaining the observed increase in arrest rates." This is the criminalization hypothesis related to increased strictness in civil commitment laws. Simply stated, when civil commitment goes down, criminal confinement goes up.

In a recent paper from our department (Bloom et al., 1981), we examined the arrest records of 189 patients who had entered the Oregon civil commitment system through our hospital emergency room. We developed a control group which consisted of ninety-five individuals who had entered the same psychiatric

unit during the same period of time as voluntary patients. To a certain extent our findings agreed with both hypotheses presented above. We found a large number of character-disordered individuals of younger age with previous arrests in both our involuntary and voluntary groups. We felt that these individuals comprise an important subgroup of those people with arrest records who also have been hospitalized. However, we did find a significantly high proportion of psychotic, and in particular schizophrenic, individuals in our involuntary group. We analyzed our findings by postulating a relationship between the effectiveness of community care and the potential for hospitalization. In other words, we do not feel that liberty automatically leads to more hospitalization. To an extent it does, but we are also postulating an intervening variable, and that variable is the quality of the community care system. Our feeling is that in the Portland area there is the combination of a highly restrictive civil commitment statute and a poorly developed community mental health system. These intervening variables lead schizophrenics, in our opinion, to the criminal justice system.

THE INSANITY DEFENSE

There is currently a developing literature attempting to understand the working of the insanity defense on an empirical basis.

In a recent report, Pantle, Pasewark, and Steadman (1980) specifically compared institutional periods of those persons found not guilty by reason of insanity (NGRI) with a matched group of criminal offenders. They found that the finding of NGRI did not lead to less institutionalization.

Singer (1978) reported on forty-six insanity acquittees in one county in New Jersey following the important New Jersey Supreme Court case of State v. Krol (1975). She pointed to findings similar to the New York state group in that the person found NGRI was often subject to long periods of institutionalization and potentially to community monitoring for life.

MENTALLY ILL PERSONS IN PRISON SYSTEMS

If we turn our attention to mental illness in the prison systems we are struck again by the paucity of empirical studies in this area. In 1980 James et al. published a study looking at psychiatric morbidity in the Oklahoma prison system. Using a stratified sample of 174 inmates who received psychological testing, the Brief Psychiatric Rating Scale, and clinical interviews, they found 35 percent of the group had diagnosable personality disorders, 25 percent had a primary diagnosis of substance abuse, and 5 percent had a diagnosis of schizophrenia. When one looks at jail populations the numbers of persons with psychotic disorders is clearly much greater. In a 1982 study by Lamb and Grant, 102 persons were randomly selected from those referred for psychiatric evaluation in the Los Angeles County jail system. Using the criteria of the Diagnostic and Statistical Manual for Mental Disorders (DSM-III), 75 percent were diagnosed as schizophrenic, 22 percent as suffering

from major affective disorders, and 2 percent from organic brain syndromes and adjustment disorders. Summarizing their findings, Lamb and Grant stated that 90 percent of the 102 inmates had previous history of psychiatric hospitalizations and 92 percent had a prior arrest record. Seventy-five percent had at least one prior felony arrest. Further, they found that more than one-third of the people evaluated at the time of the arrest had been living "on the streets, on the beach, in missions, or in cheap hotels." Only 12 percent of the group had been employed at the time of arrest. This was clearly a group with extensive experience in the criminal justice system and less so in the mental health system. It was interesting to note that only 14 percent had been receiving any form of outpatient mental health treatment at the time of arrest, and only 25 percent had ever received outpatient mental health treatment at any time. They concluded that for this group of individuals there needs to be "much more emphasis on ongoing involuntary treatment" with an emphasis on social controls, both for society and for these individuals.

My impression would agree with studies indicating high proportions of seriously disordered persons in county jails and relatively lower proportions of these individuals filtering through the criminal justice system on to prisons. It is clear from this brief review that much more current data needs to be assembled looking at epidemiological surveys for both jail and prison populations from various parts of the country.

THE YOUNG CHRONICALLY MENTALLY ILL PATIENT

Several themes emerge from the literature in the area of the young adult chronically mentally ill person. This is a group of mentally ill persons who have come into adulthood generally after institutionalization. Many have never been to state hospitals. They are highly mobile and form very impermanent relationships with treatment agencies. Sheets and associates (1982) have postulated three major subgroups of the young chronic adult patient. Group one is characterized by passive, apathetic, poorly motivated patients who form dependent relationships with service-providing systems. Group two contains individuals who are highly motivated and who function well in remission but nonetheless have serious disorders and are quite disabled, that is, individuals with limited support systems but who are highly motivated towards success. Group three is described as a "high energy, high demand group" made up of individuals who are described as aggressive and basically non-compliant. These people are described as having low tolerance for frustration and are given to impulsive behavior. They are described as highly mobile within cities, between cities, and between states. They are also described as having frequent encounters with the criminal justice system.

These studies begin to break down the chronically mentally ill population into various typologies based on diagnosis, on use of services, on disabilities, on social networks, on criminal justice involvement. It also helps us posit a group of seriously disordered persons who range between outpatient services of various types, involuntary civil commitment, and the criminal justice system. Many that enter the criminal justice system through county

jails are diverted through either civil commitment or insanity defense, with some of them filtering through to the prisons.

THE DYNAMIC BALANCE BETWEEN CIVIL AND CRIMINAL COMMITMENT

If we move from the patients to the systems designed to handle them we become convinced that the civil and criminal systems should be viewed in dynamic balance. Let us briefly examine civil commitment.

In a recent paper from the state of Washington, Durham and Pierce (1982) describe the evolution of the Washington state commitment law. The 1973 Washington Involuntary Treatment Act provided standards for commitment for only those individuals with a likelihood of committing serious harm to self or others, or persons who are gravely disabled. These standards were interpreted strictly, resulting in a limitation on civil commitment. In 1979, the Washington legislature expanded the definition of gravely disabled, allowed for more information to come into the commitment hearing, and expanded the definition of likelihood of serious harm. Preliminary data revealed a substantial rise in involuntary commitments for the six-month period following the changes in the civil commitment act. Involuntary commitments increased by some 56 percent. Durham and Pierce noted that "the effect of the revised law is the equivalent of a legislatively mandated increase in the delivery of mental health services without an equivalent increase in the resources needed to meet the demand."

In a recent paper from our department of psychiatry Faulkner et al. (1982) described local variations in the application of the civil commitment law in various Oregon counties. We found that for the past four years Oregon courts have committed 5.3 persons per 10,000 population, and that this figure has remained remarkably stable. However, we found wide variations between various county courts in their commitment rates per 10,000, ranging from 2.3 per 10,000 in one of our populous counties to 7.8 per 10,000 in another county. This type of data is interesting to us not only in trying to assess the implementation of the civil commitment statute within our various counties, but also is potentially useful in cross-state comparisons. For example, using rates per 10,000 in our data compared with the Washington data, Washington seems to commit persons roughly one-half as frequently as does Oregon. If we postulate relatively stable rates of mentally ill persons in various states, what does the Oregon rate mean when compared to the Washington rate or to a state that commits more persons? Will there be a relationship between those states that commit more people and those states that commit fewer people and to individuals with mental illness who end up in the criminal justice system? Certainly all that we know today seems to say that these types of dynamic systems relationships should exist. Further, the point of looking at civil commitment and the operation of civil commitment statutes is simply that civil commitment is a major mechanism for the treatment of mentally ill persons and a potential place for prevention of criminal justice involvement.

COMPONENTS OF THE OREGON SYSTEM

The Oregon system for handling mentally ill individuals, as it has evolved over the last few legislative sessions, can be used to illustrate what I believe is, in theory, a comprehensive system. The Oregon statewide system for mentally ill offenders has the following elements: (1) a functioning civil commitment statute; (2) a functioning insanity defense with appropriate and realistic post-insanity defense procedures; (3) diversion from the criminal justice system at the front end; (4) an adequate prison system with appropriate, on-site medical and mental health resources; and (5) specialized, voluntary treatment programs for offenders with the largest program elements devoted to substance abuse and sexual offenders and a smaller element available for the treatment of major mental disorders.

The Insanity Defense

In 1977, Oregon developed a system which was felt to be true to the moral and constitutional issues inherent in the insanity defense while at the same time being realistic about criminal behavior and public safety. After rejecting proposals to abolish or modify the insanity defense itself, the legislature concentrated on creating innovative procedures to supervise those found not guilty by reason of insanity. The legislature addressed two major problems in the old system. The first was the problem of divided authority. Each judge had maintained jurisdiction over defendants acquitted on the insanity defense in their courts, but in practice many judges deferred automatically to the opinions of state hospital staff about when a person was suitable to be released from the hospital. Those opinions naturally tended to be grounded on medical judgments about the need for further hospitalization rather than on considerations of public safety.

The second problem area was that once a person was released from the hospital there was virtually no community follow-up. Often these individuals quickly decompensated, typically after discontinuing medication, and some committed new, dangerous crimes. The result was the "revolving door syndrome."

The solution developed by the Oregon legislature to break this cycle was the creation of the Psychiatric Security Review Board (PSRB) (Oregon, 1977) which is described in more detail in a subsequent paper (Rogers, 1983). This board, which functions independently of the mental health division and of the court system, is primarily concerned with the security of society. To counterbalance this emphasis, the law provides substantial safeguards for the individual.

When a person is found suitable for conditional release, the board usually places him or her in one of the community programs developed specifically for PSRB clients, the legislature having appropriated funds to operate such programs.

A governor's task force and the legislature recently reviewed the operation of Oregon's four-year-old system. They heard testimony endorsing the continuation of the system from groups as diverse as the American Civil Liberties Union, defense attorneys, the district attorneys' association, the judicial association, and the state mental health division.

Mental Health Services for Other Offenders

In 1977, Oregon's legislature passed the Community Corrections Act. The legislative policy underlying this act is stated as follows: "It is declared to be the legislative policy of this state to establish and finance with appropriations from the general fund statewide community correction programs on a continuing basis. The intended purpose of this program is to provide appropriate sentencing alternatives and to provide improved local services for persons charged with criminal offenses with the goal of reducing the occurrence of repeat criminal offenses." The corrections division was given the responsibility to make grants "...to assist counties in the implementation and operation of community corrections including but not limited to preventive or diversionary correctional programs, probation, parole work release, and community correction centers for the care and treatment of criminal defendants." This correctional program "...shall be made available only to misdemeanants, to parolees, to probationers, and to persons convicted of other than murder, treason, or Class A felonies." The Community Corrections Act established a statewide community corrections advisory board to review and act upon plans from local county community corrections services. The 1979 legislature appropriated $687,000 in the mental health budget and $687,000 in the correctional budget for local mental health services to offenders who fall within the groups defined above. County mental health programs received this money in relation to two criteria: (1) the county's willingness to participate in the community corrections act and (2) that mental health services would be available within the mental health clinic in the particular county. As can be seen in its original design, offenders can be referred to local community corrections programs either as an alternative to state correctional institutionalization or upon release from state correctional institutions. A mechanism was thus developed to bypass or shorten institutional stay by making opportunities available for both correctional and mental health services on the local county level.

Specialized Voluntary Treatment Programs for Offenders

Another step is the relationship between mental health and corrections developed in the 1979 legislature. Independent of each other, the state hospital population in Oregon was dramatically falling while the state penitentiary population was increasing. With the inordinate expenses involved in the construction of new correctional institutions it was natural for state government to look to the already constructed state institutions, namely the state hospitals, to develop programs which would in a sense help to reduce overcrowding in the state penitentiaries and at the same time develop programs

for specific offender groups. With the increased use of the "not responsible" verdict which followed the early change from M'Naghten to American Law Institute (ALI) criteria and continued after the creation of the PSRB, an additional sixty beds were created at the Oregon State Hospital for the institutional care of those persons committed to the PSRB. This created a total of approximately 160 inpatient beds for this particular population. The 1979 legislature made monies available to the Oregon Mental Health Division to remodel space at the Oregon State Hospital to handle an increased number of transfers from the Oregon State Penitentiary.

A cooperative agreement between the corrections division and the mental health division was developed in 1980 in order to "delineate the responsibilities of the Corrections Division and the Mental Health Division providing mental health services to a correctional client who is in need of and can benefit from mental health services." With this basic agreement in hand, the mental health division issued an administrative rule for the care and treatment of correctional inmates assigned to and transferred to the mental health division. Provisions were made for the transfer of inmates with "inadequate social skills," with "mental or emotional disturbance," with "mental retardation," with "sexual behavior problems," and with "substance abuse problems." The mental health division was expected to use existing services and to develop new services within the state hospitals for these defined populations. Transfers were to be handled on a joint basis and for the most part only voluntary admissions would be accepted by the mental health division. Inmates are accepted into the mental health programs close to the effective dates of either the completion of their sentence or eligibility for parole. Discharges for parole were to be handled by the corrections division in their usual manner. Persons completing mental health programs could then be referred through the community corrections program for outpatient care.

CONCLUSION

It can be seen by the trends noted above that there is a clear movement within state government in Oregon for the use of both institutional and community mental health programs for designated offender populations. This trend was continued by the 1981 legislature, which rewrote the Oregon Community Mental Health Act by designating the chronically mentally ill patient as the highest priority group to be served by the statewide mental health system. As this trend develops, the designated chronically mentally ill patient, the quasi-offender found not responsible by reason of mental disease or defect, and the convicted offender might form the nucleus of the community mental health system in Oregon.

No one knows the percentage of persons who should fall into the varying categories. What, for example, are ideal rates per 10,000 population for civil commitment, for insanity defense, or for that matter, incarceration? As we begin the fine-tuning of research in this area we may get closer to the answers and perhaps to more smooth running and more careful responses to these very difficult problems.

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PLANNING FOR FORENSIC SERVICES

by

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Editor's Note: Before planning effectively for "forensic services" Dr. Shah believes one must have a fairly clear idea of what is meant by such services and for whom those services are designed. Definitions of forensic services and mentally ill offenders are key to avoiding confusion and misunderstanding in later stages.

The use of "forensic services" by Dr. Shah refers to the mental health evaluation and treatment of persons who have come into contact with the criminal justice system and who are in need of mental health services.

Because definitions of mentally ill offenders are key in effective planning for "forensic services," the following are categories of persons who are often included under the term mentally ill offenders, even though some are not "offenders" in the strict sense of having been convicted of crimes.

- Persons involved in the determination of their competency to stand trial and those receiving treatment after having been adjudicated incompetent.
- Persons involved in determinations of their criminal responsibility and the postadjudication care and treatment of those who have been acquitted on grounds of insanity.
- Persons who have been adjudicated as "guilty but mentally ill."
- Persons who have been adjudicated as sexual psychopaths, sexually dangerous persons, and the like, under provision of these special statutes.
- Convicted offenders referred for presentence evaluations.
- Seriously mentally ill offenders transferred to mental health facilities (usually security hospitals or units) from penal institutions.

- Mental patients transferred from civil to security hospitals because of their dangerousness or other related considerations.

- Various other convicted offenders, whether under institutional or community correctional supervision, who are in need of mental health services.

The foregoing is meant to be a fairly complete, but by no means exhaustive, listing of the types of persons subsumed under the term "mentally ill offenders." In several states, primarily because of the shortage of appropriate security facilities, mentally retarded and developmentally disabled offenders may also be referred to security mental hospitals.

A PLANNING FRAMEWORK: OVERVIEW

- Keep in mind the major societal goals and objectives that are to be addressed, as well as the basic values that undergird and guide these goals (see, e.g., Shah, 1977).

- Try to develop a sound information base regarding the problems to be addressed (e.g., obtain accurate information about the number and rates of cases in the system, the factors that seem to determine and control "the flow rate" of these cases, etc.) Accurate information is essential for informing and guiding planning, related policy, and programmatic decisions. Lacking such a systematic information base, an assortment of assumptions, beliefs, ideological preferences, and speculations will tend to push policy decisions. (Unfortunately, some of the recent furor about the insanity defense tends to be inadequately informed or guided by a sound knowledge base. Hence, some of the proposed "solutions" are not likely to make contact with the "problems" they are ostensibly designed to address.)

- A sound knowledge base provides the starting point for a number of other important considerations. These include (1) realistic assessment of the resources needed to address stated program objectives (e.g., facilities, staffing, budget); (2) determining what other states and jurisdictions (preferably those with fairly similar laws, organizational structures, funding provisions, size, and demographic features) have done with regard to the same or similar problems, and with what degree of success; (3) assessing essential differences and the need to adapt approaches and models used in other jurisdictions to fit the precise needs of the new setting; and (4) being sensitive to the sociopolitical realities that must be considered.

- There should be some good monitoring and evaluation as a basic part of planning and programming for various service delivery systems. Such evaluation components can provide the feedback

essential for determining how the policies and programs are actually being implemented and with what success. Such feedback also will indicate the need for necessary adjustments and changes.

- It is important to keep in mind the various institutional, budgetary, and related contingencies that tend to influence organizational and agency functioning. For example: (1) given the lack of proper facilities and staffing needs, as well as other related problems, mentally disordered offenders tend at times to be tossed back and forth like the proverbial "hot potatoes" between correctional and mental health agencies; and (2) notwithstanding certain constitutional provisions, the desirability of using "least restrictive alternatives," and considerations of cost-effectiveness, the aforementioned budgetary and related contingencies influence courts to overuse (or make inappropriate use of) security hospitals for evaluations which could be done on outpatient basis. The controlling contingencies will need to be considered in seeking to change such practices. (Note the experience of Tennessee in regard to a major shift from hospital-based to outpatient evaluations, as reported by Marthagem Whitlock elsewhere in this report. See, also, Laben and Spencer, 1976; Laben et al., 1977; Slobogin, 1981.)

SOME SPECIFIC ASPECTS OF PLANNING FORENSIC SERVICES

As mentioned previously, a key aspect of effective planning and programming for forensic services is to have a clear idea of the nature, size, and scope of the relevant forensic service system (as I have defined the term) in the particular jurisdiction. Also important is information about how requests for referrals tend to be made, at what specific points in the legal-mental health process, and what alternatives are available (or may need to be developed) to provide the requested services.

It must be added that information about the number and rate of various referrals for services does not provide all the needed information for planning. It is essential to ascertain how many of the referrals are <u>appropriate</u> in reference to stated purposes and relevant criteria. Lacking information about the appropriateness of the referrals, one may end up planning for more services (e.g., security bed space) than actually is needed or could properly be justified. For example, if needed mental health evaluations could be done on outpatient bases for $200-$400, it does not make sense to send large numbers of such cases to the security hospital where the cost could well be ten times higher.

For the effective use of available mental health staff, it is important to ensure that legal or administrative guidelines are not unnecessarily restrictive concerning the professional background of the examiners (e.g.,

limiting such evaluations to psychiatrists). A broad terminology of "qualified mental health professional" is clearly preferable and could allow better use of staff resources, especially in states with relatively few mental health professionals.

Because persons have basic training in the core mental health professions (i.e., psychiatry, clinical psychology, clinical social work, and psychiatric nursing) does not merit the assumption that such persons are sufficiently knowledgeable about and competent to conduct various psycholegal evaluations in reference to specific legal issues. Proper training and certification programs should be developed to ensure satisfactory levels of knowledge about the relevant legal and mental health questions.

As much as possible, security hospitals and units should function primarily and mainly as mental hospitals and not as "psychiatric prisons." The proper role of these facilities as places for the care and treatment of persons with serious mental disorders will tend to be vitiated and eroded if they are used mainly for purposes of secure confinement. Thus, "hard-to-handle" prison inmates should not be "dumped" in security hospitals. Rather, necessary mental health consultation and services should be provided to correctional institutions.

To ensure proper use of available mental health services to the extent possible, agencies making referrals for service should assume at least some of the costs for the requested services. Lacking such budgetary contingencies it is likely that requests for services will not be considered carefully and more cost-effective alternatives will not be utilized fully or developed when needed.

Mental health facilities and professionals need to be properly modest about the kinds of problems that they can reasonably address. For example, treatment of mental disorders, even when quite effective, does not automatically or even necessarily influence criminal recidivism. Similarly, prevention of relapse and postrelease criminal or violent behavior due to recurrence of serious mental disorder is not to be achieved through predictive assessments made in the hospital. Rather, prevention of relapse and related protection of the community will hinge on the nature, closeness, and quality of the follow-up and related services provided to patients after they leave the hospital. Such aftercare programs should be essential parts of the program of the forensic and related mental health service delivery system--especially with regard to mentally disordered offenders (e.g., those who have already demonstrated their propensity for serious criminal behavior).

Mental health professionals working in the area of mental health law and forensic services have an ethical obligation to become well-informed about the legal issues and questions that relate to their assessments of patients. They also need to be aware of a variety of related issues pertaining to their role and functioning vis-a-vis their patients, the agencies for which they work, the legal system, and the larger society. (See, e.g., Monahan, 1980; Shah, 1981, pp. 248-252; Task Force Report, 1978.)

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COORDINATING THE MENTALLY ILL OFFENDER SYSTEM: THE HAWAII MODEL

by

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Editor's Note: Interagency cooperation is the key to the success of the Hawaii mentally ill offender system. The state mental health agency provides leadership to the effort through its Courts and Corrections Mental Health Team. The team, administered by the mental health agency, provides services to the correctional institutions, the family and adult court system, and youth and adult parolees and probationers. On the recommendation of the Governor's Commission on Crime, the legislature is considering a bill to establish a state forensic center that would centralize responsibility for examination, treatment, and custody of potentially or actually mentally ill offenders.

Hawaii is a leader in the region in coordinating programs and services for mentally ill offenders provided by law enforcement, courts, correctional facilities, and mental health facilities. The state mental health agency and its Courts and Corrections Mental Health Team provide leadership to the interagency effort but all agencies are expected to participate actively in improving communication and developing a smoothly functioning system to meet the needs of mentally ill offenders. Some interagency mechanisms include:

- Regular meetings of the Forensic Center Committee composed of representatives of law enforcement, courts, corrections, and mental health, the various agencies to address ongoing problems in communication, referral, or service provision;

- Establishment of interagency task forces to address high priority problems. Currently a task force is considering ways to improve discharge and aftercare services and to strengthen community evaluation and treatment;

- Mental health forensic training in which twelve agencies make presentations regarding their programs and policies;

- The mental health corrections team provides daily assistance to each of the state courts in evaluating defendants arrested the previous day.

HISTORY OF THE PROGRAM

Mental health services to the criminal justice system in Hawaii are divided into three main components that together comprise the forensic program. Forensic services as a separate entity began in 1958 with the creation of a "corrections mental health team." This consisted of one psychiatrist, one psychologist, and one psychiatric social worker. These three mental health professionals were broadly assigned to the corrections division to cover the state prison, parole board, two Neighbor Island camps, the Hawaii youth correctional facility, and the youth parole board. A decision was made when these positions were created that since the state corrections division had no experience in hiring and supervising mental health professionals, the positions should be administratively located in the mental health division of the department of health and assigned by special agreement to the corrections division. This was an important decision that later was to have many advantages including the fact that such services can be delivered with greater professional independence and integrity if they are not directly controlled by the receiving agency.

This pattern of supplying mental health services to the entire criminal justice system from the mental health division is still in effect. Since 1958, the mental health team for corrections has expanded to include two additional psychiatrists and two additional psychologists. In 1967, the family court was created in Hawaii and one psychiatrist and one psychologist were assigned to serve this court and since then one psychologist has been added along with one psychiatrist and one psychologist for the adult criminal courts. There are now a total of five full-time psychiatrists, five full-time psychologists, and one psychiatric social worker assigned to the criminal justice system on Oahu. A clinical psychologist heads the mental health team for courts and corrections.

Hawaii is comprised of four main islands or counties. The Island of Oahu (Honolulu) contains approximately 80 percent of all the population and related human services. The other three islands are Maui, Hawaii, and Kauai. The eleven professional members of the mental health team for courts and corrections are assigned primarily to Oahu. On the Island of Hawaii, there is a full-time psychologist assigned to all of the courts and corrections programs on that island. On the Island of Maui, there is a half-time psychiatrist assigned to these programs; and on the Island of Kauai, all services to the criminal justice system are performed by the local mental health center.

Hawaii is somewhat unique in that all of the courts in the state are under the State Supreme Court (there are no county courts) and all of the local jails are under state administration. Thus, the entire state court system and the entire state correctional system including jails are under state administration and these programs are covered by the services assigned from the mental health team for courts and corrections.

SERVICES PROVIDED BY THE COURTS AND CORRECTIONS TEAM

Basic services to the correctional institutions include evaluations and review of cases on intake and for parole consideration. A special mental health ward is operated inside the state prison for mentally ill inmates. If needed, an inmate can be transferred to the Hawaii State Hospital security unit. Services are also provided to the youth offenders in the Hawaii Youth Correctional Facility and transfers when appropriate are made to the adolescent unit of the state hospital. Services are available to inmates both at the request of the administration and upon personal request.

Services to the family and adult court system include disposition evaluations, waiver cases, sanity commissions, and related matters including in-service training and some research.

At any one time, there are approximately 5,000 people in Hawaii who are in touch with the criminal justice system by virtue of being incarcerated or on parole or probation, including youth and adults. A total of twelve mental health professional positions are assigned to cover this population.

FORENSIC HOSPITAL

In 1975, the Hawaii State Hospital set aside a separate section of a ward provided with security for penal cases. Largely due to the change in the civil commitment procedures since 1975, the security unit has developed into a total of three completely separate wards which comprise the "Closed Intensive Security Unit (CISU)." There are a total of eighty-three beds on all three wards. One of the wards is designated as maximum security and contains most of the serious felony offenders. The other two wards are largely populated with misdemeanants sent to the hospital for mental evaluation. The CISU has a total of three psychiatrists, two psychologists, three social workers, and a total nursing staff of seventy-two. In addition there are two recreational therapists and a part-time occupational therapist. Admissions to the CISU units are for:

1. mental examination;
2. for treatment after an acquit and commit verdict;
3. for an unfit to proceed finding;
4. as a condition of probation, and;
5. as a part of a presentence examination for convicted offenders.

The CISU unit serves the entire state.

COMMUNITY PROGRAM

The third and most recently formed component of the forensic program in Hawaii consists of mental health professional liaisons between the state hospital patients and the local mental health centers. Follow-up services for

patients conditionally released from the hospital and for persons on probation or parole when mental health services have been ordered are provided by the local mental health centers where the clients reside. Monitoring services are provided to see that the court-ordered services are followed. There are currently approximately fourteen individuals involved in this program.

One unique program started approximately two years ago involves a mental health evaluation each morning (Monday through Saturday) as the defendants arrested the previous day are brought to the courts for arraignment by the police department. When any of these arrested individuals are suspected of being mentally ill and unfit, they are immediately sent to the state hospital rather than spending any time in jail. This program has been extremely effective in avoiding the dangers and complications of mentally ill persons going to jail.

FORENSIC TRAINING

A mental health forensic training program is provided. The purpose of this program is to orient and initiate new employees to the various programs and activities involved in forensic work. Approximately twelve agencies make a presentation during this training to acquaint the workers with their programs and policies. These agencies include: the State Crime Commission, the Honolulu Police Department, the Sheriff's Office, Prosecutor's Office, Public Defender's Office, Intake Service Center, Family Court, Adult Criminal Courts, State Prison, Youth Correctional Facility, Intake Service Center, Parole Board, Courts and Corrections Branch, and the Closed Intensive Supervision Unit at Hawaii State Hospital.

HAWAII FORENSIC CENTER

The Forensic Center Committee is hoping to formalize some of the interagency procedures and suggestions for improving the MIO system through passage of legislation to set up a Hawaii State Forensic Center. Creation of the Forensic Center was initially recommended by the State Commission on Mental Health and Justice in 1980 and was one of eight recommendations made by the Governor's Crime Commission which conducted a study in 1981-82 examining the functioning of the insanity defense. A bill to set up the center was introduced in the 1983 session of the legislature.

The center would centralize responsibility for the examination, treatment, and custody of those who raise the mental health issue in a criminal proceeding. The forensic center would also maintain data, conduct research on those it examined, educate and train mental health professionals, and monitor those released on conditional release.

Advantages of the center were noted in the Governor's Crime Commission Report in the following terms:

> It seems that the existence of a state forensic center in Hawaii would improve the administration of the law in several important aspects. First, it would help stem abuses of the insanity defense by improving the process of determining responsibility. It would create guidelines, educate and train the professionals conducting the examinations, and standardize examinations. Second, it would foster improved public safety by closely monitoring those released into the community on conditional release. Third, it would provide a mechanism for adjustments in the system as conditions change with the need for such adjustments detected through continuous research and data collection. Fourth, it should improve the reputation and, thus, effectiveness of the Hawaii State Hospital by assuming the task of custody of the penal code patients. All of these improvements would address shortcomings in the existing system.
>
> (The Mentally Ill and the Criminal Justice System, p. 76)

CONCLUSION

Hawaii's experience has been that developing a good mental health program for the offender population requires frequent and meaningful communication among all agencies and personnel dealing with offenders. Although considerable time and effort is needed to organize and maintain an ongoing network, the results in terms of planning, legislation, service coordination, and improvement in the total system is worth the effort.

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PRETRIAL FORENSIC EVALUATION AND TREATMENT IN TENNESSEE

by

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Editor's Note: Forensic services is an area of mental health care which has been extensively developed in Tennessee. Forensic services in Tennessee are generally defined as services to those adults who have come into contact with the criminal justice system and who are in need of some form of mental health evaluation or treatment. The primary focus, however, is on insanity and pretrial evaluation of competency to stand trial. Until 1972, the maximum security unit at Middle Tennessee Mental Health Institute was the sole agency responsible for providing forensic services for the entire state. Since that time, the delivery of forensic services has been decentralized so that community mental health centers and the five state psychiatric hospitals now provide a variety of forensic services on the local and regional levels. However, the maximum security unit--now known as the Forensic Services Division--is still the only secure facility.

The main reason for changes which have occurred in forensic services was the U.S. Supreme Court's decision in Jackson v. Indiana, 406 U.S. 715 (1972). Jackson had been determined to be incompetent to stand trial because he was mentally retarded, deaf, and mute. After being found incompetent to stand trial, he was committed under Indiana law to a mental hospital and detained for three and one-half years on the basis of his incompetency to stand trial, even though his condition did not meet the standards necessary for a civil commitment.

The Supreme Court held in Jackson that a pretrial defendant could be hospitalized in a mental hospital for only a reasonable amount of time in order to determine the issue of competency to stand trial and could not be hospitalized indefinitely unless the same standards and procedures were used that are required for the civil commitment of a noncriminal mental patient. Once the defendant is committed, he must be given the treatment both appropriate for his condition and directed toward helping him attain competency. If the defendant is incompetent but not committable, he must be released unless other provisions can be made.

As a result of this decision, the Tennessee Department of Mental Health and Mental Retardation evaluated all the patients at the Forensic Services Division using the standards specified in the Jackson decision, and, as appropriate, initiated civil commitment for each patient who remained

incompetent to stand trial and was unlikely to attain competency in the near future, and transferred each patient whose behavior did not require maximum security to the regional psychiatric hospital closest to his or her home.

In addition, the department reviewed several pieces of literature that supported change: Matthew's American Bar Association report, Steadman's Baxtrom studies, McGarry's research, Caplan's community mental health concepts. Consequently, the services were changed in Tennessee for these individuals with special attention given to defendants before trial.

SERVICE DESIGN AND DELIVERY

The service delivery was designed with five issues which are to be considered concurrently. Forensic service delivery should be:

(1) supportive of best legal tradition and precedent;

(2) accessible to the court, defendant, and defendant's family to continue communication with community and significant individuals;

(3) cost-effective by providing adequate and appropriate services at lowest possible cost to the mental health and criminal justice systems;

(4) based on concepts of least restrictive setting consistent with protection of the community from client dangerousness; treatment should be the same as for any other committed patient;

(5) recognized as a specialty with peculiar needs and responsibilities (active coordination is essential for system definition and maintenance).

The department assessed and utilized resources already available for mental health service provision:

(1) an existing decentralized mental health system (the commissioner made mental health funds contingent on providing forensic services);

(2) Law Enforcement Planning Agency (LEPA) seed money to begin forensic evaluation teams in the metropolitan areas starting in 1973; and

(3) cooperation of local criminal justice system.

A new forensic state law was passed which provided the statutory framework for new policies. These imposed strict procedures for admission and discharge to any inpatient forensic program but particularly to the maximum security unit. It also required courts to refer pretrial defendants to community mental health centers for evaluation; only after outpatient evaluations can inpatient evaluations occur. The department's policies also allow for the inclusion of a variety of mental health professionals in

providing both the clinical services when an emergency situation arises as well as the pretrial forensic evaluation. Consequent to the involvement of a variety of professionals, the department implemented a training and certification process and promulgated rules and regulations significant to the mental health professional's involvement in the forensic process.

Since these changes were instituted beginning in 1974, the department has carried out a number of things for standardization of services:

(1) established a quality control mechanism by the development of standards for service provision and program evaluation;

(2) established data retrieval and monitoring with special collection of additional data by the Special Services Section, and;

(3) established and reinforced the role of the central office administration of a forensic program.

The responsibility for this standardization of services rests with the Special Services Section and includes an articulation of a philosophy, long-term planning, policy and procedure formulation, consultation, technical assistance, monitoring for quality control, and monitoring for adherence to law, training, and certification.

STAFF TRAINING AND CERTIFICATION PROGRAM

The expansion of forensic services to numerous agencies required the department to recognize professionals other than psychiatrists to provide forensic evaluations. A training program was developed to prepare the individuals to deal with legal issues and to familiarize the criminal courts with the quality of evaluations which could be performed on the local level.

Initially, all mental health center training took place at the maximum security unit in Nashville. The maximum security unit provided the only population from which to draw an individual to interview for training purposes. This situation was far from ideal: many issues involved in the evaluation process could not be illustrated since this was an incompetent population; training for certification was one day in length and provided too little time to allow the evaluators to receive and assimilate information which represented a new approach to an interview, new issues, and a change from the client advocate stance mental health professionals are trained in; training in a centralized location meant a lengthy and costly trip which many professionals could not make without at least one overnight stay representing considerable time away from the mental health center for staff already strained for treatment time and travel money.

In 1976, a new training program was implemented. Required participation in training for mental health center personnel was expanded to two full days

for initial certification, allowing for a separation of the issues of competency to stand trial and mental condition at the time of the alleged offense as well as a much more thorough approach to issues in the forensic evaluation process.

Along with the newly decentralized training came the mobilization of training for convenience and accessibility to mental health center staffs. In order to mobilize, varying components of the training process were developed and video taped. The total training requirement was expanded: certification was to be renewed annually (now biennially) by participation in a continuing education program in forensics, recognizing that the field is so transitional that this is required to keep abreast of its status. This effort is assisted by periodic mailings regarding critical developments in the field.

Training at mental health institutes remains one day in length but is usually conducted in two half-day sessions in order not to so dramatically impact staff coverage. Focus is for both mental health professionals eligible for certification by the Tennessee Department of Mental Health and Mental Retardation and ward personnel. The issues remain essentially the same as identified for mental health center professionals, but focus is on inpatient observation, evaluation and treatment, rather than outpatient screening.

CONCLUSION

The impact of these changes has been to reduce the number of maximum security beds from approximately 380 to forty-eight. Forensic services are provided by five forensic evaluation teams, twenty-eight community mental health centers, five regional mental health institutes, and one maximum security unit. These pretrial facilities provided a total of 1,797 outpatient forensic evaluations during 1980-1981 and 289 hospitalizations for evaluation. The cost of a forensic evaluation is approximately $200 on an outpatient basis and approximately $4,050 on a thirty-day inpatient basis.

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THE PSYCHIATRIC REVIEW BOARD: A MODEL FOR SUPERVISION OF INSANITY DEFENSE OFFENDERS

by

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Editor's Note: Jeffrey L. Rogers, former chairman of the Oregon Psychiatric Security Review Board, presents a look at the insanity defense and its problems and importance as a plea and suggests some modifications to improve its effectiveness. Rogers describes how the Oregon legislature approached the problem of hospital overcrowding caused by an influx of offenders found innocent by reason of insanity by creating the Psychiatric Review Board in 1978. The review board has complete jurisdiction over the treatment of these individuals. He describes in detail the board's procedures in supervising these offenders in the hospital and in the community treatment program and concludes by summarizing the wealth of data accumulated on individuals who are found "not responsible," Oregon's version of the not guilty by reason of insanity plea.

Much of the data and explanation of data in this article was previously published in somewhat different form in the Bulletin of the American Academy of Psychiatry and the Law, Volume 10, Number 3, 1982. WICHE acknowledges the permission of the American Academy of Psychiatry and the Law to reprint this material.

The preliminary question is why pay much attention to the insanity defense at all. The number of people successfully utilizing the insanity defense is quite small. For instance, in New Mexico there is less than an average of one person per year who prevails on the insanity defense; in Wyoming, approximately one per year out of eighty-three attempts at using the insanity defense; twelve to fifteen per year in Idaho; maybe thirty a year in Hawaii, somewhat higher. A number of states do not keep any data on it. Oregon, even though its population is relatively small, has probably the highest number of the western states--about 100 per year. But even 100 per year comes out to less than one in 1,000 criminal cases in Oregon. So it is a relatively small phenomenon in terms of numbers.

It is, however, worth paying attention to for a variety of reasons because it has impact on the mentally ill offender and on all of those who deal with mentally ill offenders. First of all, the insanity plea is in a sense the end of the road for the mentally ill offender. When all else fails in the criminal system, when the defense attorney has nothing else to do, he/she looks at

the insanity defense. Secondly, there is a relationship between the insanity defense, civil commitment, and competency to stand trial. Decreases in civil commitments may lead to increases in criminal commitments. States which have few insanity pleas may have proportionately more incompetency proceedings. Another area that the insanity defense relates to is mentally ill offenders in prison. Does a lower rate of using the insanity defense result in a higher number of mentally ill offenders in prison?

Another reason that the insanity defense is important is that it has a substantial impact on public perceptions of a number of things. For instance, public perceptions of psychiatrists in terms of testimony in court; public perceptions of mental health division personnel and prison personnel in terms of the release of people who are seen as crazy and dangerous; lawyers perceived as combining with crafty psychiatrists and psychologists to get people off the criminal charges and set them free. It certainly has impact on the public perception of the mentally ill themselves. The attention that the media give to sensational cases involving usually schizophrenic individuals in various kinds of bizarre killings is well known to all of us. The overall basic impact of the insanity defense in terms of public perception is a negative one. Therefore, it is worthwhile to try to construct a reasonably rational and responsive system for dealing with even the small numbers of people involved.

In the early 1970s the Oregon situation was quite typical. A number of problems existed. The hospital population of people found not guilty by reason of insanity was skyrocketing, there was an overcrowding problem in the hospital, and mental health people brought that to the attention of the legislature.

Second, there was a "revolving door syndrome" in which individuals who were released from the hospital essentially were given no follow-up supervision whatsoever. The typical pattern was to go off medication, become actively psychotic, start acting out again, perhaps committing new dangerous crimes, be right back in the system with a couple of headlines about what that person had done and how the doctors and judges had let this dangerous person out with no follow-up. In answer to those problems and the public anger about them, the 1977 legislature considered what to do about this problem.

TWO APPROACHES TO MODIFYING THE INSANITY DEFENSE

You might categorize two general approaches to modifying the insanity defense. One is tinkering with the test itself. That is what the federal system is looking at doing--abolishing the defense. That is what I understand Idaho has just done, abolished the defense. A number of states have instituted guilty but mentally ill verdicts in addition to an insanity defense. Oregon looked at that approach and rejected it. They decided there was not that much wrong with the test, which in Oregon is the American Law Institute (ALI) test, probably the most prevalent around the country. Instead the Oregon legislature looked at another approach to the insanity problem.

That is, what happens to those persons who employ the insanity defense? What happens if they are found not guilty because of insanity? What decisions would be made regarding hospitalization, releasing from hospitalization, and aftercare following release?

THE PSYCHIATRIC REVIEW BOARD

Oregon's legislature created the Psychiatric Security Review Board (PSRB). This is a five-person board created by statute and made up of part-time members, each having another occupation or profession of his own. By statute the governor-appointed board consists of a psychiatrist and a psychologist not employed otherwise by the mental health division, a lawyer familiar with criminal law, a person familiar with parole and probation, and a lay citizen. Their sole function is to make decisions about those people found not guilty by reason of insanity (NGRI). They do not deal with MIOs in any other context. They are independent of the mental health division, answerable only to the governor. The board meets about once a week to conduct hearings. Substantial due process rights are given the client similar to a criminal trial, including representation, appointment of counsel if indigent, right to cross examine, and right to see all the information used. The state may have an attorney present. Psychiatrists, social workers, state hospital representatives, and outside experts who have evaluated the individual make recommendations. The board also has a full-time staff who coordinate board functions and teatment programs which are set up in varous counties around the state.

The program is designed with an emphasis on security. The statute provides that the board shall have as its primary concern the protection of society, which I think is a pretty unusual provision to have in a statute. There is no question that the board's function is protecting the community and that is the way the board approaches its decisions. But that emphasis on security and control is balanced with substantial due process rights for the individual. It is of some interest that the program seems to be popular in Oregon among people who are familiar with it. When it was created in 1978 it was set up to be experimental and to go out of existence in 1981 unless the legislature renewed it. Prior to the 1981 legislative session there were extensive hearings on it and a task force of the legislature concluded that the program was operating well and should be continued.

THE REVIEW BOARD PROCESS

What happens to an individual who pleads not guilty by reason of insanity in Oregon? In a typical trial conducted by a judge or jury, the defendant may be found not guilty and released, found guilty and sent to prison or put on probation, or found not responsible (NR). The latter finding is Oregon's version of "not guilty by reason of insanity." If the defendant is found NR, there is a second decision made by the judge. First, whether the individual continues to present a substantial danger to others. Second, whether the individual continues to be affected by mental disease or defect. If the

answer to either of those questions is no, the person goes back to the street. That doesn't happen very often. We don't have hard data yet, but it seems in most instances that with persons found NR, the judge almost always makes a finding that he continues to be dangerous to others and continues to have a mental disease or defect. If the answer to both of those questions is yes, then the person is placed under the jurisdiction of the PSRB and from that point on, the review board controls. The judge has no continuing jurisdiction, and no authority, and the mental health division has no authority over the decisions made about whether that individual is hospitalized, placed in a community setting, or discharged.

The PSRB meets periodically, reviews each case about every six months, and makes decisions as to placing individuals in one of three situations: in the hospital through commitment; on conditional release to a community treatment program; or discharged and freed of any further supervision. In making that decision, the board considers the same questions that the judge has to answer at the outset, that is, does the person continue to present substantial danger and does the person continue to be affected by a mental disease or defect. If the board continues to answer both questions yes, the person stays under the jurisdiction of the board for up to the maximum period of time he/she could have been sentenced if convicted (e.g., if the offense was murder, the individual could be under the board's jurisdiction for life; if a class A felony, he/she could be under the board's jurisdiction for twenty years). Preliminary indications are that individuals are staying under the board's jurisdiction for substantially longer periods than they would have had they been convicted and sentenced, for example, to twenty years, which might be reduced to ten years with good behavior, possibly paroled in two years, kept on parole for six months, and then freed. In the PSRB system, because the board has to keep asking these questions, some persons stay under the board's supervision for longer periods than if convicted.

The individual can be discharged from the board short of the maximum sentence if one of three things occurs: the maximum "sentence" has expired, the board determines that the person no longer has a mental disease or defect, or the board determines the person is no longer dangerous.

COMMUNITY TREATMENT PROGRAMS

In order for this type of system to work there must be adequate supervision and treatment available in the community as well as in hospitals. Oregon has set up treatment and supervision programs in the counties specifically to deal with these kinds of individuals. They are not just referred to county mental health clinics. The experience in Oregon, and I suspect many other places, was that county mental health clinics were not well equipped to deal with MIOs who were seen as dangerous, not at all inclined to accept treatment, and who needed a great deal of supervision as well as therapy. Prior to the creation of these programs designed for them, insanity defendants released to the community tended to fall through the cracks and disappear until they committed a new crime.

The legislature has appropriated $1.1 million since the creation of the board in 1978 to create specialized programs such as the Providence Day Treatment Program in Portland. This program has a unit specifically set up for day treatment for NR individuals. It has psychiatrists who provide therapy and medication. It has social workers who provide various kinds of therapy during the day. And it has case managers who, with social workers, work on helping the individual get employment or schooling (if they are able to do either of those two things) and housing. A lot of social support work is done. The case manager, or sometimes an actual probation officer assigned by the board, reports to the board promptly (by telephone if necessary) any deterioration or dangerous behavior. This program is associated with a private hospital in Portland which is on contract with the state mental health division to provide these services.

SUPERVISION DURING REMISSION

A key policy innovation in the Oregon law is the statutory requirement that the board retain jurisdiction over those individuals whose disease, and resulting dangerousness, is in remission. This is designed to take care of a frequent problem in which psychotic offenders are hospitalized, placed on medication, involved in treatment and improved to a point where they are no longer actively ill. It used to be that patients were discharged by a judge at this point. Patients often discontinued community treatment, stopped taking medication, became actively psychotic and dangerous, and committed new crimes.

Now the board retains jurisdiction and arranges for supervision in the community and return to the hospital if necessary. The board receives reports from the case manager or whoever is assigned to supervise the individual usually within twenty-four hours of any deterioration or any kind of dangerous behavior. The police are authorized to arrest that individual based on the board's warrant of revocation and to return that individual promptly to the hospital. That usually happens within twenty-four to forty-eight hours of the first signs of real problems. The signature of the chairman on one piece of paper based on an affidavit is sufficient to issue a warrant for the police to pick up the individual; that happens frequently.

DATA ON PSRB ACTIVITIES

The board has kept records which provide a rich source of data for research and analysis. Prior to creation of the board, there was no data on numbers of individuals using the insanity defense or what happened to them, except while actually hospitalized. Now there is detailed data available, and we are in the process of analyzing that data. We have computerized the information so we can locate every individual under the review board's jurisdiction at any time, record actions taken by the board, and include where the individual was placed, subsequent criminal charges, and discharges from PSRB jurisdiction. We are going to use that to make additional correlations which

will add to the relatively skimpy empirical base around the country. We have an opportunity to look at what really happens in one state whose use of the insanity defense is high. This may be of interest to other states in determining whether it makes sense to expand the insanity defense but to control it with a kind of mechanism such as Oregon has. Data here will be presented in the following areas: jurisdiction and demography, trial court variables leading to the findings of NR, psychiatric characteristics of the population, hospitalization and conditional release, and finally discharge from jurisdiction.

Jurisdiction and Demography

Over the three-year existence of the PSRB 440 individuals have been known to be under the jurisdiction of the board at one time or another. This includes those persons whose supervision was inherited by the board from the courts as well as those found not responsible since January 1, 1978, when the board commenced operation.

Some individuals legally under the board's jurisdiction have never been identified by the board. This is because the board assumed jurisdiction on January 1, 1978, of all persons previously found not guilty by reason of insanity who were still under the jurisdiction of the courts. In some instances, the court's supervision or even record keeping was deficient and courts could not identify the names of all such individuals.

However, over time the courts were able to identify 141 individuals who had been found "not guilty by reason of insanity" prior to the commencement of operations by the PSRB on January 1, 1978. These persons were transferred to PSRB jurisdiction as they were identified. In 1978, there were an additional ninety-seven individuals found not responsible and placed under the board's jurisdiction; in 1979 there were 116, and in 1980 there were eighty-six such dispositions (Table 1).

*As noted in the Editor's Note, much of the following data and commentary is reprinted with permission from the Bulletin of the American Academy of Psychiatry and the Law, Volume 10, Number 3, 1982.

TABLE 1

Commitments to PSRB Jurisdiction

January 1, 1978 (transfers from court jurisdiction)	Number	Total
	141	141
New Commitments:		
1978	97	
1979	116	
1980	86	
1978-1980		299
	Total	440

Of these persons, 400 (91 percent) were male, 40 (9 percent) were female. Their ages at the time they were found not responsible range from 17 to 74 with distribution as shown on Table 2. The mean age for the entire group was 30.8 and the median was 28.

Table 2

Age at time of not responsible finding

Age	# of individuals (N-440)	Percent
17-19	20	05
20-29	229	53
30-39	115	26
40-49	41	09
50-59	19	04
60 +	10	02
Unknown	6	01

Trial Court Findings

Certain data available reflects the various trial courts' handling of the insanity defense. From December 8, 1978, through July 10, 1981, the board held hearings on 359 individuals. Reconstructing what occurred in the trial court as to these individuals, it was striking that only twelve persons (3 percent of the total) were shown to have been found not responsible by jury verdicts. All the others were adjudged without presentation to a jury. Furthermore, 283 of the total, 79 percent, were found not responsible as a result of agreement or stipulation between the state and the defense with only the formality of concurrence by the court. Sixty-four (18 percent of the total) were found not responsible in a contested hearing by a judge sitting without a jury.

It is also important to note that 85 persons (19 percent) were found not responsible of misdemeanors; with the remaining 355 (81 percent) found not responsible of crimes including at least one felony. However, the percentage of persons being found not responsible only of misdemeanors has climbed in each of the past three years. Data for these three years is summarized in Table 3. We are preparing a separate report on the misdemeanor client committed to PSRB. Our belief is that the commitment of these persons represents an important bridge between the criminal justice system and the civil commitment system, and may reflect problems in the latter system.

Table 3

Persons committed to PSRB following misdemeanors, 1978-1980

Year	Persons committed following misdemeanors	Total committed	Percentage misdemeanors (%)
1978	19	97	19%
1979	29	116	25%
1980	27	86	31%
Sub-totals	75	299	25%
Pre-1978* (known cases)	10	141	7%
Total	85	440	19%

*The small number of pre-1978 misdemeanants transferred to PSRB jurisdiction may reflect in part that judges likely lost track of misdemeanants more frequently than felons.

Table 4 presents the original charge of those persons committed to the jurisdiction of the PSRB. Where an individual was found not responsible of multiple charges, only one was listed in the table. This was selected in the judgment of the authors as either the most violent or most serious charge, with the most violent charge taking precedence. Attempts were not listed separately except in the case of murder and attempted murder.

Psychiatric Characteristics of the Population

Although the PSRB deals with a population found not responsible by reason of mental disease or defect, psychiatric diagnosis is a major problem. These individuals have been diagnosed for the court usually by at least two experts, either psychiatrists or psychologists. They are then diagnosed again for the PSRB by the receiving state hospital and often by other experts brought in to reexamine individuals for the purposes of PSRB hearings. Even though the population has been extensively diagnosed there is a great deal of suspicion about the diagnoses offered by anyone connected with the process.

Table 4

Criminal Charge - Commitments to PSRB

Charge	Total # (N=440)	Percent
Murder	24	5
Attempted murder	22	5
Manslaughter	10	2
Kidnapping	10	2
Rape	15	3
Sodomy	12	3
Sex abuse	17	4
Robbery	38	9
Assault	62	14
Arson	26	6
Burglary	50	11
Unauthorized use of vehicle	48	11
Theft	22	5
Criminal mischief	14	3
Menacing	10	2
Oisorderly conduct	9	2
Trespass	9	2
Recklessly endangering	8	2
Weapons charges	5	1
Driving charges	6	1
Other	23	5

For the purposes of this report, we have listed in Table 5 the primary diagnoses provided by the state hospital on persons under the PSRB jurisdiction. No claim can be made at this point on the criteria used for these diagnoses, or, for that matter, for the diagnoses offered in the trial courts which frequently differ from those made by the state hospital. Primary diagnoses are listed for 373 persons. Sixty-seven people of the 440 studied for this paper were either never admitted to the state hospital, or if admitted, had no diagnosis on the chart or were still in the evaluation phase without diagnosis. Of the 373 persons diagnosed, 251 (67 percent) were felt to be psychotic, with 228 (61 percent) diagnosed as suffering from schizophrenia. The next leading diagnostic group was the personality disorders, including alcohol, drug abuse, and sexual conduct disorders. The group comprised 20 percent of the total sample for whom diagnoses were made by the state hospital personnel.

We are able to report some comparison data on diagnoses between the state hospital staff with those made by other examiners, either during the preceding court process or at the request of the review board or patient to present to the board at hearings. We have kept such comparative data on 274 individuals who have appeared consecutively before the board by recording the "primary"

Table 5

Primary Diagnosis (by State Hospital Staff)

Diagnosis	Total (N=373)		
	N	Total	%
Psychosis		251	67
Schizophrenia	228		
Affective	21		
Paranoia	2		
Organic Brain Syndrome	24	24	6
Neurosis	5	5	1
Personality Disorder		74	20
Antisocial	10		
Inadequate	10		
Passive-aggressive	5		
Sexual conduct disorders	8		
Drug dependent	5		
Alcohol dependent	15		
Paranoid	5		
Other	16		
Mental Retardation	17	17	5
No Mental Disorder	2	2	1

diagnosis of such individual. The primary diagnosis has been taken to be that diagnosis constituting the most severe mental disorder displayed by that individual. Findings are summarized in Table 6.

In 80 percent of the cases (220 individuals) all the psychiatrists or psychologists examining the individual generally agreed on the primary diagnosis although there was some difference in terminology use. Sixty-six percent of the total were agreed to be affected by a psychotic illness, 5 percent to be retarded, 4 percent to be affected primarily by organic disorders, and only 5 percent were agreed by all to display only personality disorders and no major mental illness.

However, in 20 percent of the cases (54 individuals) there was a major disagreement among two or more of the examiners as to the correct primary diagnosis. By far the most prevalent disagreement was the hospital staff concluding that an individual displayed only a personality disorder when at least one other examiner concluded that the same individual was affected by a psychotic illness. This is highlighted by noting that, as shown in Table 5, the hospital staff diagnosed 20 percent of PSRB commitments as displaying primarily personality disorders; by contrast, in only 5 percent of PSRB commitments studied were all examiners in agreement that the patient displayed only personality disorders (Table 6).

Table 6

Agreement/Disagreement Among Examiners on Primary Diagnosis

	N (%)	Total (N = 274) Total	%
Agreement		220	80%
Psychosis	182 (66%)		
Organic Brain Syndrome	11 (4%)		
Mental Retardation	14 (5%)		
Personality Disorder	13 (5%)		
Major Disagreement		54	20%

Hospitalization and Conditional Release

In this section, we will focus on the conditional release aspects of the board's jurisdiction.

During the first three years of its existence the PSRB monitored 165 individuals who were on conditional release during one or more periods. These individuals accounted for 1,929 person-months on conditional release. During that time sixteen individuals on conditional release were charged with new crimes. These are listed, along with judgments and disposition of these cases, in Table 7. The most serious new crimes have been airplane hijack and rape. A driving incident resulting in two counts of manslaughter occurred early in the fourth year of the PSRB operation.

New criminal charges constituted grounds for revoking of conditional release. However, the board also revoked releases when an individual committed unacceptable acts not resulting in criminal charges, or when an individual's mental health deteriorated, or the person violated major conditions of release. During the first three years the board issued sixty-nine orders of revocation on sixty-six individuals. This represented a much higher rate of revocation than ordered by the courts before the board came into existence. From 1972 to 1977 only eight individuals are known to have been revoked by the courts. At least twenty-seven other persons technically under PSRB jurisdiction had been placed on conditional release by the courts prior to January, 1978, but were never located to be actively monitored by the PSRB.

Table 7

New criminal charges filed against individuals on conditional release

Individual	Charge(s)	Judgment	Disposition
1	Theft 1.....	Dismissed	
	Hijack.....	Guilty.....	Prison
2	Driving under influence.....	Guilty.....	10 days jail
3	Burglary II.....	Dismissed	
4	Robbery.....	Dismissed	
5	Theft II.....	Dismissed	
	Harassment		
6	Simple Assault.....	Guilty.....	Fine/Probation
7	Driving while suspended.....	Dismissed	
8	Assault (misdemeanor).....	Dismissed	
9	Rape 1, att. elude, trespass....	Guilty.....	10 years prison
	Escape II.....	guilty.....	1 year jail
10	Theft of services, harassment...	Dismissed	
11	Illegal shooting of cow elk.....	Guilty.....	Fine
12	Felony driving while suspended..	----	
13	Driving while under influence, hit and run.....	----	
14	Fraudulent use of credit card...	----	
15	Unlawful use of weapon.....	Guilty.....	10 days jail, suspended
16	Theft II.....	Dismissed	
17*	Manslaughter (2 counts) Assault II.....	Not responsible (stipulated finding)	Recommitment to PSRB Jurisdiction.

*This individual charged during January, 1981.

Discharge

During its first three years the PSRB discharged 144 individuals from its jurisdiction. Fifty-six of these were discharged as required because the maximum jurisdictional time of the PSRB had elapsed. Of the remaining persons, thirteen were discharged because the board concluded that evidence no longer showed the person to be affected by a mental disease or defect, fifty-eight because the evidence no longer showed the person presented a present or future substantial danger, and seven individuals for the combination of both reasons. Five persons on conditional release committed suicide and one died of natural causes. Four were discharged for miscellaneous procedural reasons. Table 8 gives additional details.

Table 8

Discharges from PSRB jurisdiction

Reason for Discharge:	1978	1979	1980	Total
1. Expiration of maximum jurisdictional period	16	21	19	56
2. Finding of no longer affected by mental disease or defect	1	0	12	13
3 Finding of no longer presenting substantial danger	0	19	39	58
4. Combination of both findings in columns 2 and 3	0	3	4	7
5. Ordered by Appellate Court	0	0	*1	1
6. Natural death	0	1	0	1
7. Suicide	2	0	3	5
8. Mandatory hearing not held	2	0	0	2
9. Other	0	1	0	1
Total	21	45	78	144

*later reversed by Supreme Court

TREATMENT IN FORENSIC HOSPITALS AND PRISONS

Editor's Note: Treatment programs for the mentally ill offender are found in a variety of settings. Most western states provide the most extensive treatment in forensic units of state hospitals. State prisons generally employ a small cadre of mental health professionals to evaluate mentally ill clients, to provide medication and limited treatment, and, occasionally, to provide in-hospital or day-care type activitiy within the prison. And community treatment programs--in outpatient, day care, and halfway house settings--are possible alternatives to hospital care or means for providing aftercare for offenders released from hospitals or prisons.

Conference participants met in small groups to discuss issues and problems relating to treatment programs for various mentally ill offender client groups. This section summarizes those sessions, including the following presentations:

The Clinical Program at Lake's Crossing Center, Carlos Brandenburg, Ph.D., Program Director, Lake's Crossing Center, Reno, Nevada

Treatment Program at the New Mexico Forensic Hospital, Richard T. Fink, Ph.D., former Director of Psychology, New Mexico State Forensic Hospital (Dr. Fink is now in private practice in Santa Fe, New Mexico)

Arizona State Prison Complex Mental Health Treatment Program, Gary Selvy, A.C.S.W., Coordinator, Mental Health Program, Arizona State Prison

A Systems Perspective on Community Treatment of Mentally Ill Offenders, Roger Enfield, Ph.D., Director, Central New Mexico Psychological Services

The Therapist's Role in Treatment of Mentally Ill Offenders, Breck Lebegue, M.D., A.P.C., Director of Forensic Psychiatry, University of Utah

TREATMENT IN HOSPITALS

The two forensic hospitals discussed at the conference (Lake's Crossing Center in Reno, Nevada, and the New Mexico State Forensic Hospital) focus on treatment, rather than evaluation. The Lake's Crossing Center's primary mission is to restore to competency and return to the judicial system those who were admitted as incompetent to stand trial. To a lesser degree, Lake's Crossing prepares some clients for return to the community if: (1) charges against them are dropped; (2) they were sent there from the state prison as a condition of parole; or (3) they were found not guilty of a crime by reason of insanity.

In New Mexico, forensic evaluation teams conduct 90-95 percent of the court-ordered evaluations, freeing the hospital to expand its services to include more treatment of special populations, specifically institutional transfers from the penitentiary and probationers referred from the courts. At any one time, approximately ten of the ninety hospital beds are taken up by evaluation cases, thirty-five to forty by institutional transfers from the penitentiary, twenty by probationers, and twenty by "treat until competent" cases.

Richard Fink, who described the program at the New Mexico Forensic Hospital, noted that institutional transfers and probationers are similar in that both groups are convicted felons who can benefit from treatment not available and/or not possible within the department of corrections. They share one or more of the following traits:

1. They are mentally ill.

2. They lack a significant criminal history and antisocial attitude.

3. The nature of their personalities and their crimes are such that they could not function in the penitentiary.

4. They are invested in self-improvement and positive change.

5. There is substantial likelihood of improvement so that they could lead a crime-free life after release.

One of the prime examples of this type of client is the sex offender with offenses against children. Many of these people have no other criminal history and cannot interact with "cons." They end up on the bottom of the pecking order where their lives are in danger. Such a situation forces them to stay in protection for their whole sentence.

The first goal of the forensic hospitals discussed at the conference is to quickly resolve psychosis, which is the major fact preventing clients from being competent to stand trial or ready to live in the community. Fink said many of the clients sent to the hospital because they were found incompetent to stand trial are in an actively psychotic state due to schizophrenia or a bipolar disorder. They usually can be medicated and quickly regain competency.

Therapeutic Interventions

The New Mexico Forensic Hospital, briefly, uses a therapeutic community model in which clients work their way through different levels. By demonstrating increased responsibility, the clients earn increased privileges and freedoms. Other special treatment such as group and individual therapy takes place within this framework.

Carlos Brandenburg described in detail the therapeutic interventions employed by the Lake's Crossing Center. First the center concentrates on building a relationship between the client and his primary therapist, who is called the sponsor. Daily meetings between these two individuals are used to build trust and to make sure the client feels he has an understanding, caring ally. The remainder of the client's treatment team also builds a special--but less intense--relationship with the client. The sponsor becomes the main person the client can go to for help with any daily living problem, request for a privilege, etc., thereby cementing the bond between them. Within the framework of this bond, the sponsor can exert influence on the client in terms of getting the client to act appropriately, think and talk clearly, etc. The sponsor can translate into action the treatment plan, which is developed by the client's entire treatment team, and lead the client through it.

A second therapeutic intervention is the use of focused therapeutic activities. Some of these are verbal in nature, such as groups for orientation to the facility, reality therapy, and discussion of legal processes. Others are physical, such as occupational and recreational therapy. These activities, written into the patient's treatment plan, are designed to provide structured interactions that promote attention, concentration, and clarity of thinking. Some activities serve a dual purpose: the legal processes group is also educational and activities such as occupational therapy have the added benefit of making clients feel good about their accomplishments.

Both interaction with the sponsor and therapeutic activities promote social interaction, which is a major problem for psychotic patients. Through these activities, the client finds it increasingly difficult to retreat into his own world and increasingly rewarding to stay with the world most of us occupy.

The third therapeutic intervention used at the Lake's Crossing Center is the use of a token economy system. This system provides reinforcement in the form of tokens, or points, for the client's participation and progress in his treatment plan. The client can trade points for items from the canteen or various privileges, such as watching television, using the pool table, etc. Even very psychotic patients, who have no interest in doing anything to help themselves, respond to such tangible reinforcement. The staff structure each client's program individually to reward those activities the client has the most problems with. For example, staff rewards one client for being neat and clean, another for each five minutes of social interaction he engages in, and another for five minutes of logical conversation. The clients know what they can be rewarded for because it is explained to them and is written on their

point sheet, which they carry with them at all times.

The fourth intervention is the use of chemotherapy. While the center does not force medication on clients unless they are imminently dangerous to themselves or others, staff will offer psychotic clients medication and reward them with points for taking it. Some psychotic clients refuse medications, and the center gives them that right as long as they do not become imminently dangerous. Staff rely primarily on their developing relationships with clients to convince them that medication may benefit them, such as helping them get back to trial or out into the community.

Special Services at the Lake's Crossing Center

In addition to the therapeutic interventions designed to resolve clients' psychoses, the center provides services to address the broad range of individual problems clients present. Many problems are covered in individual therapy sessions, but the center also offers a variety of specific therapy groups on anger, substance abuse, human sexuality, leisure time. Therapy sessions are also held for families of clients. An educational program serves clients who want to work on the GED or remedial education.

Extensive discharge planning helps prepare clients for living and working in the community. Planning includes a community living therapy group, increasingly complex outings in the community, vocational rehabilitation and job hunting, and interagency meetings with aftercare staff. When clients are discharged, the center staff escort clients to their new destination and make the first follow-up visit, when that facilitates a smooth transition.

Evaluation

The Lake's Crossing Center spends a considerable amount of time performing psychiatric, psychological, and psychosocial evaluations on all clients. The evaluations, which frequently address issues of competency or criminal responsibility, are sent to court and become the basis for subsequent testimony by the center's professional staff. In many cases, the evaluations have a significant impact on the results of legal proceedings.

Brandenburg said the interventions used at the Lake's Crossing Center have enabled the center to accomplish its mission quickly and efficiently with a relatively short average length of stay and a low recidivism rate. The center serves the interests of clients and society by helping the judicial process move along and by making sure that clients who leave the center can function in a way to maximize their success.

A PRISON MENTAL HEALTH TREATMENT PROGRAM

The Arizona State Prison Complex (ASPC) is a large prison that includes four different custody classes: intensive custody, maximum security, medium security, and minimum security or outside trusty. The mental health program

is located in the maximum security area which houses approximately 1,000 inmates. However, the mental health program provides services for the other three units as well.

There has been recognition of the mentally ill population at the prison for some time, and there was an attempt to house them in one cell block several years ago. The inmates were also seen by a psychiatrist who tended to prescribe heavy doses of antipsychotic medication, and they were essentially separated from the other prison population.

In the fall of 1980, a class action suit against the prison was resolved with a court order mandating the provision of mental health treatment for those in need, and that inmates who need inpatient care be transferred to the Alhambra Reception and Treatment Center in Phoenix.

As a result of the court order, a mental health program was developed in the maximum security unit. The relatively new program has a staff of four nurses, one recreation therapist, one social worker, four substance abuse counselors, one psychiatrist, one secretary, and the director of the program.

There are special problems in developing a mental health program in a maximum security prison. Of major consideration is the fact that security issues are far more important--and take precedence over--treatment issues. Also, the mentally ill inmates have problems relating to general population inmates, and therefore, housing must be segregated. While it is possible to segregate their housing and even develop special recreation areas, it is impossible to totally segregate many other day-to-day activities: law library, recreation field, dining hall, chapel, and theater, to name a few.

Three Categories of Inmates

Inmates needing mental health care tend to fall into three different categories:

- Residents who are violent, dangerous, and combative in almost all situations. At any given time, ASPC has approximately ten such residents and special housing will be developed to care for them. These chronically dangerous patients are very difficult to treat and only infrequently respond to any form of treatment. Their care and treatment is considered long term.

- Chronic, long-term patients who do not tend to be violent or dangerous. This group includes the chronic-schizophrenics, the mentally retarded, and the organic brain syndrome patients. These residents usually have a long history of mental illness and are generally not responsive to treatment. Environmental considerations are primary and must be highly structured to include a care and treatment atmosphere. Typical approaches to these inmates by security staff are generally ineffective and often lead to unnecessary confrontations. On the other

hand, we find mentally ill residents easily managed when the emphasis is on a therapeutic basis.

- Acute-chronic patients. These residents respond to antipsychotic medication and individual and group psychotherapy, as well as day treatment in the form of recreation or occupational therapy. They can be expected to function normally in the general population following treatment.

The Arizona State Prison Complex has developed a mental health unit consisting of fifty-four cells. The residents' placement depends upon which of the three categories they are in and the phase of the category they are in. The approach to the residents is primarily behavioral, and all work with residents in the program is controlled through the use of therapeutic contracts. Privileges are spelled out and agreed upon between the case manager and the resident.

Problems in Prison Mental Health Treatment

Unanswered questions have to do with whether it is appropriate or feasible to develop a mental health program within a maximum security facility. Providing the most effective treatment for mental illness in a prison is difficult. Certain fundamental treatment principles and techniques are outside the control of a mental health staff in the prison including:

- Moving clients to the least restrictive treatment appropriate to their needs;
- Encouraging a client's independent functioning and taking responsibility for his own actions;
- Gradual reinvolvement in his home community and continued support from mental health staff during this process;
- Discharge at the point the client has received maximum benefit from the program.

The prison emphasis on punishment, control, and regimentation is not conducive to rehabilitation efforts to help clients learn to be more independent, to function adequately in the community, and to make use of community supports to cope constructively with their mental illness.

On the other hand, developing mental health programs in prisons is less expensive than developing new outside programs and provides at least some level of mental health services to a large number of inmates who have received no treatment in the past and would probably not be transferred to mental health facilities if prison programs are not available. As prison programs identify the needs of mentally ill inmates more specifically, it may be possible to make prison programs more responsive to these needs and/or to work with state mental health agencies to develop a continuum of services, partly

by corrections and partly by mental health, to meet a client's changing needs for treatment.

Treatment Intervention in Correctional Settings

In Lebegue's discussion of the therapist's role in treatment of mentally ill offenders, he points out that in choosing the most effective level and mode of intervention, therapists should be aware that the approach is different depending on whether the clients are in custody or not. Large jails or prisons should be well staffed with either consulting or on-site mental health personnel. The size of the staff will vary with the size of the institution, of course, and large facilities may benefit from a small, inpatient psychiatric unit for the treatment of psychoses, organic brain syndromes, alcohol withdrawal, drug reactions, etc.

Many more mentally ill offenders are ending up in the county jails as a result of the narrowing of the civil commitment laws. This is so because, as fewer persons are subject to the social sanctions of the mental health system through involuntary commitment, more are subject to social control of the criminal correctional system. The effect is like squeezing one end of a balloon: the air doesn't go away, it just moves someplace else. County jail personnel should be especially careful in the assessment and treatment of acutely intoxicated or ill inmates, as these conditions may mask other more serious mental or physical pathology. It never pays to do sloppy evaluations, as jail administrators and personnel have been held liable in personal injury suits by inmates whose complaints elicited indifference rather than adequate medical and/or mental health attention.

When these mentally ill inmates are convicted of crimes, they may either be sentenced to prison or granted probation. Prisons around the country are now developing a large in-house "outpatient" population of mentally ill inmates with treatable illnesses, such as schizophrenia, mood disorders, and alcoholism, and legislative attention should be paid to this phenomenon if the principle of rehabilitation in order to reduce criminality is a greater social goal than retribution.

On the other hand, incarceration may be avoided if these same defendants can be maintained in a socially nondangerous state on probation as a result of effective mental health intervention. These same disorders particularly are responsive to psychopharmacologic intervention, which requires little participation from this largely nonmotivated group of offenders.

TREATMENT IN THE COMMUNITY

Another aspect of treatment receiving increasing attention by legislatures and state mental health and corrections agencies is community treatment in outpatient, day care, and halfway house settings. Such treatment may be an alternative to hospital treatment or aftercare for offenders who have received treatment at the forensic hospital or in prison and may be conditionally

released to less restrictive treatment or discharged and referred for follow-up.

Information on the offender population indicates that many of the MIOs have histories of psychiatric disturbance and often have been shuttled between the civil and criminal mental health systems. These individuals may do well while on medication or while in mental health treatment programs but decompensate on return to the community (or to the prison) if medication or treatment is not continued. They are a difficult group to engage in outpatient treatment on a voluntary basis. Their need for ongoing support and assistance dealing with day-to-day problems of daily living indicates their need for a community approach similar to the community support systems for the chronically mentally ill (CMI). Community mental health systems are often reluctant to accept referrals of MIOs into their programs for CMI because of their disruptive or violent behavior and because community resources are less than adequate to meet needs of other chronically mentally ill who are not offenders.

Roger Enfield points out two general problems in community treatment programs for the MIO. First, there is a lack of coordination and communication between the institutions and the community, between the mental health and criminal justice systems, and among agencies in the community. Both the institution and the community need to know what the other will do to fill the vast gap between the total environment of the institution and fragmented community resources--when and how can each rely upon the other to meet their joint responsibilities?

The mental health and criminal justice systems--very different in their mandates, philosophies, and remedies--are forced to work together in dealing with mentally ill offenders. Coordination between these diverse systems is essential because of the possible negative effect of communicating through and conveying expectations to dependent persons such as MIOs.

The need for coordination between community agencies is especially apparent in statistics on interprogram transfers. Hankoff et al. (1974) report that interprogram transfers may have a no-show or early drop out rate of more than 90 percent. Enfield reports that a study of interagency coordination in which he participated led him to determine that this rate may be as high as 50 percent, even with extra planning and care. Using these two rates, it is clear that a four-agency obstacle course (such as hospital to day care to vocational assessment to job training) will be completed by no more than 2 to 12 percent of all who begin it.

When multiple agencies try to help these multiproblem clients, they all too often end up competing for the more workable clients, unloading the less workable, and blaming one another for the resulting defeats. The current balkanized status of community programs militates against any easy resolution of interfacility problems, which often has a devastating effect on the bargaining and conflict resolution position of programs with both the large institutions and funding bodies.

Second, mentally ill offenders themselves are difficult to work with, especially in community settings. The MIO population shares with other needy populations a tendency toward pervasive and numerous behavioral deficiencies across life areas, problems which may well require, sequentially or simultaneously, the services of many agencies. But perhaps unlike other needy populations, the MIO tends toward lamentable behavioral excesses in areas involving drugs, alcohol, impulse control, and--often--violence. The MIO may require not only intervention management but also risk management and difficult trade offs between therapeutic opportunity and community safety. Planning for community treatment must take into consideration who can be served with available resources and must recognize who can be served best and who cannot be served at all.

THE THERAPIST'S ROLE IN TREATMENT OF MENTALLY ILL OFFENDERS

Lebegue identifies some of the pitfalls and factors therapists need to consider in treating mentally ill offenders. A therapist who treats mentally ill offenders should ask the questions "What am I doing here?" or "Whose idea was this treatment anyway?" This relates both to personal issues, which will be dealt with later, and professional issues, the most important of which is a decision regarding whose agent the therapist will be. By that is meant not only who is paying for the therapist's time and, therefore, has charge of his actions, but who is interested in the therapist treating mentally ill offenders, and what are the motivations of these persons. Most commonly, it is the state's interest in social control through the mental health system (rather than the correctional system) by mental health techniques and methods. In other words, the unstated goal is the diminution of social dangerousness by using behavioral, social, psychological, medical, psychopharmacological, and other techniques that fall within the realm of mental health expertise. The therapist should carefully consider these covert expectations of the institutions and the system within which he/she is considering working, and be prepared to factor them into the equation for personal happiness and professional work satisfaction.

Accurate and Specific Assessment

If the therapist has considered these factors and agrees to work within these systems, there is an implicit assumption that the goals of the state and employer (diminished dangerousness through mental health techniques) will become the goals of the therapist. It follows that one should be well versed in the relative uses of these techniques so that they may be applied specifically and accurately to the variety of mental pathology that may be seen. This requires an accurate and specific diagnosis and assessment, so that condition-specific treatment may be planned. It is not enough to merely sit down in the same room and talk with someone over a variety of subjects. The therapist must have specific goals in mind and know the most effective method of reaching those goals. Thus, symptoms such as depression, irritability, or hostility may signify biologic psychiatric syndromes which are best treated with mood-stabilizing or neuroleptic medication; on the other hand, it is not enough to

expect that the lifestyle changes associated with alcoholism will remit simply because one prescribes antabuse.

It does not hurt to be humble in these situations. There is no reason for any individual therapist to be out on the end of a limb alone making treatment decisions in correctional institutions. Consultation with colleagues, peers, supervisors, etc., should be used frequently, both for the therapist's own education and for the benefit of the client or patient. This need for consultation is especially true when ethical issues arise, such as privilege, confidentiality, reporting of uncharged crimes, etc.

Realistic Expectations

Treating personnel must learn to project realistic outcomes. Nothing has so alienated supervising judges and probationers as the rosy-tinted prognoses predicted by optimistic but inexperienced mental health personnel, which do not come true. Many of these conditions are lifetime disorders, subject to periodic and serious decompensation, and supervisory personnel should be informed of this in no uncertain terms. Unfortunately, supervisors rarely are informed of these facts because mental health personnel tend to "go to bat" for a defendant who may espouse the principles of treatment prior to sentencing but fall back after having been given the opportunity to prove himself. Prognosis should be based on scientific fact, gleaned from thorough study of theory and recent literature, and should not be based on therapeutic hunches, feelings, or patient promises.

Indeed, the therapist should seriously examine his/her own reasons for becoming involved in the treatment of the mentally ill offender in the correctional system. Too often such involvement results from unresolved issues on the part of the therapist, resulting in an unconscious drive to rescue, grandiosity, masochism, or other major conflicts. These are not nice people to work with, the institutions are not nice places to work, and yet, unfortunately, these factors are all too often suppressed for unconscious reasons. A therapist with unrealistic expectations is quickly disillusioned, and worker burnout leads to a lot of casualties for these reasons. Particularly dangerous is the therapist who obviously affects the mannerisms, lifestyle, language, or beliefs of the criminal population. Excuses that this style "lets him know he can trust me" should delude no one.

The therapist should make efforts to protect him or herself as well. It is remarkable how an inexperienced therapist may naively carry the assumption that he/she can somehow magically walk amongst this population without harm, almost as if by divine protection. Mentally ill offenders are some of the most dangerous people to work with and the therapist should take all reasonable precautions to assure himself of the opportunity to write his memoirs. A full clinical discussion is precluded by space limitations, but obvious factors to consider are developing and maintaining good rapport with the patient, marshalling support in the form of sheer numbers in dealing with an agitated patient, avoiding placing oneself in compromising situations, knowing the physical layout of the area, etc.

Confidentiality

Finally, protection of information is important to both client and therapist. The client should be immediately informed at the first meeting of the nature (usually nonconfidential) of the impending relationship, and the need for notification of others and possible action if immediate dangerousness is anticipated. This not only lets the client know in exact terms the nature of the relationship, but can begin to provide the external structure that the patient lacks internally. The information about the client should be carefully protected and privacy assured in questionable situations.

Of particular importance is the separation of treatment from court-ordered evaluation of a county jail population. Local mental health centers usually are charged with the acute treatment of the mentally ill offender in county jails. In order to assure adequate rapport with a patient in a somewhat hostile environment, the jail therapists must be able to assure the patient that these treatment records will not become immediately available to the courts, prosecutors, probation officers, or others without some degree of patient consent. Court-ordered evaluations should be carried out by separate personnel for these reasons.

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ANALYSIS OF RECENT LEGAL DEVELOPMENTS AFFECTING MENTAL HEALTH CARE DELIVERY SERVICES TO STATE PRISONERS IN NEW MEXICO

by

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Editor's Note: Dr. Muxlow's perspective on legal developments affecting mental health care delivery services to state prisons in New Mexico is that of a state lawyer who has been working with the New Mexico Corrections Department for the last six years. Over the years he has been involved with implementing applicable court decisions in the mental health area for prisoners and has been involved in advising the department mental health care personnel on implementation of legal decisions and in litigating particular cases.

The legal framework regarding mental health rights of prisoners is constantly changing. Thus mental health care treatment of prisoners is continually being affected by changes in the legal framework. It is important to keep abreast of recent legal developments on this subject, and there have been some very significant recent developments. I will discuss some of these developments in the context of the New Mexico system. It is important to examine and be aware of recent legal developments in order that states can develop plans and strategies to deal with legal, political, and other changes as they occur.

Our New Mexico system of mental health care delivery to prisoners is a dual agency approach. On the one hand we have the Corrections Department, an incarcerating agency, whose principal responsibility under law is to incarcerate persons and provide them with the rights and privileges of incarcerated persons. On the other hand, we have the Health and Environment Department, essentially a treatment agency, whose responsibility is to provide mental health care treatment to persons coming under its jurisdiction. These persons are primarily not prisoners as prisoners alone would be a very small portion of the mental health care delivery system of the Health and Environment Department. However, at various times there are anywhere from ten to forty state-committed prisoners under the jurisdiction of the Health and Environment Department as well as a number of preadjudicated persons who are there either because they are incompetent to stand trial or for a diagnosis of whether they are competent to stand trial.

When we examine the legal framework surrounding this issue, we find that there are fundamental differences and different problems in the separate and

distinct legal frameworks within which each of these two agencies must function. This leads naturally to an examination of what is the best approach to providing adequate mental health care to people in custody. Should we take the status quo and build on that, or, as some have suggested, should the Corrections Department establish a treatment hospital under its jurisdiction to provide appropriate mental health care delivery services to prisoners who are both acute and chronic mental cases. There is an additional pervasive question, which may some day be legislatively addressed, as to which agency's responsibility it is to provide mental health care to state-committed prisoners.

Historically, the dual agency approach has not produced much formal interaction as it pertains to incarcerated prisoners needing mental health care. Until the summer of 1981 the Health and Environment Department, because of lack of space and staff, were able to provide only about ten beds in the Forensic Treatment Hospital for New Mexico prisoners.

In the summer of 1981, the Health and Environment Department created an additional small treatment facility, primarily for chronic mental health patients, and this allowed for transfer of up to thirty additional prisoners from the Corrections Department to the Health and Environment Department. This project is very expensive and was funded jointly at that time by the Health and Environment Department and the Corrections Department. But even this extraordinary undertaking was not considered an answer to all the mental health care needs of all inmates under the jurisdiction of the Corrections Department as there was and is today a waiting list for inmates awaiting transfer to the Health Department. This was an important step forward but continuation of this program is in doubt because of funding problems.

Until now, there has been no significant mental health care treatment facility under the jurisdiction of the Corrections Department. Now, however, as part of the post-riot renovation of the Penitentiary of New Mexico at Santa Fe, there is being created a small Forensic Hospital, primarily for acute patients.

The dual agency approach in New Mexico is associated with a dual legal framework. There are separate laws and court decisions imposing requirements on the Health and Environment Department, the treatment agency, and separate laws and court decisions imposing requirements on the Corrections Department, the incarcerating agency. Serious questions arise when a state-committed prisoner is transferred to the Forensic Treatment Hospital under the jurisdiction of the Health and Environment Department. After he has been transferred, what is his status? Does he have the rights and status of a prisoner or does he have the rights and status of a mental health client, or does he have some sort of dual status?

There is not an easy answer to this question. I think it is fair to say that when such a prisoner is so transferred, he has some rights and the status of a committed prisoner under the Corrections Department system but he may also have some rights and have the status of a mental health client who is committed under the laws applicable to mental health clients in general.

Let me give an example of an actual case and we will see how some of the various laws and court decisions impact on a particular situation. John is a middle-aged inmate who has a significant criminal history including violent crimes. He has been in and out of jails and prisons for the last several years. John also has a significant history of psychosis, paranoid schizophrenia, and he has been in and out of mental hospitals during the past several years.

In early 1981, John, who was then a prisoner at the Penitentiary of New Mexico (PNM) at Santa Fe, refused to take psychotropic medication which was prescribed for him. The main purpose of the psychotropic medication was to allow him to function "normally" and to destroy his religious delusional system.

The dilemma for the PNM treatment staff in early 1981 was what to do with John at that time. PNM did not administer involuntary psychotropic medication to John and PNM would have liked to have transferred him to the Forensic Treatment Hospital where he probably would have been subjected to involuntary psychotropic medication, but John did not want to go voluntarily to the Forensic Treatment Hospital. One reason he didn't want to go is because he didn't want to have to take medication. But it was obvious to the treatment staff at the penitentiary at that time that he was daily decompensating at PNM without medication, likely to become violent. He was not in a very good treatment environment.

John's case became the first under Vitek v. Jones for a determination as to whether or not John would be transferred involuntarily to a mental hospital. The Vitek v. Jones case was a 1980 United States Supreme Court case which held that prisoners could not be involuntarily transferred to a mental hospital without some minimal procedural due process requirements. These involved notice and a hearing and right to counsel. The critical questions at a Vitek hearing which were to be examined by the hearing panel were whether the prisoner was suffering from a mental illness, disease, or defect and if he was, could he adequately be treated for this condition at the prison. If not, then he could be involuntarily transferred to a mental hospital.

John was the first New Mexico prisoner to be involuntarily transferred to the Forensic Treatment Hospital. About five or six months later John, while still a prisoner but residing and being treated at the Forensic Treatment Hospital, filed a petition for writ of habeas corpus in the local district court. He claimed that he had the status of a mental health "client" within the meaning of the New Mexico mental health and developmental disabilities code and was entitled to all the rights under that code (rights not available generally to prisoners under Corrections Department jurisdiction), and that since he had not been getting those rights from the Forensic Treatment Hospital, he was entitled to be discharged from the Forensic Treatment Hospital and transferred back to a facility under the jurisdiction of the Corrections Department.

The writ was defended on the basis that John was a prisoner and had solely that status, but the judge disagreed and held that John was entitled to the

rights and privileges under the mental health and developmental disabilities code. The court ruled that the rights and procedures of the mental health and developmental disabilities code applied to John's confinement at the Forensic Hospital. The court held he had the right to refuse psychotropic medication because the Forensic Hospital had failed to obtain an initial order of commitment not to exceed thirty days, because the hospital had failed to obtain a subsequent order of commitment not to exceed six months, and because the hospital had failed to obtain the lawful consent of John for the administration of such medications. The court ruled that continued restraint of John at the Forensic Treatment Hospital was unlawful. He was ordered transferred back to the Corrections Department where he is today. A decision was made not to appeal the decision. The decision was based on the definition of client under the mental health and developmental disabilities code. The definition of client under the code is any patient who is requesting or receiving mental health services, or any person requesting or receiving developmental disabilities services, or who is present in a mental health or developmental disabilities facility for the purpose of receiving such services. Thus the definition of client under the code is broad enough to include state-committed prisoners who are transferred to the Forensic Treatment Hospital by the Corrections Department and it is broad enough to include those who are sent to the Forensic Treatment Hospital in preadjudicated status. The definition of client does not exclude prisoners or anyone sent to the Forensic Treatment Hospital. Convicted prisoners do not by legislation have the rights of civilly committed persons, but persons committed because they do not have the mental capacity to stand trial do have such rights by statute.

Another court decision which should be mentioned is the Duran case. The provisions of the mental health care policy statement of Duran are basically in line with standards promulgated by the American Correctional Association but the whole issue of involuntary administration of psychotropic medication, for example, now needs to be examined in light of Duran. I mention this because of its impact in a case such as John's. Under traditional decisions, psychotropic medication can be involuntarily administered to inmates under certain circumstances and this does not constitute a violation of the prisoner's right to be free from cruel and unusual punishment. However, one of the provisions of the Duran decree is that all inmates committed to the department may only be given mental health care treatment without his or her informed consent pursuant to the standards of the New Mexico mental health and developmental disabilities code. I am not sure exactly how this provision will be interpreted but unless prisoners are excepted out of the mental health and developmental disabilities code by legislation, then there is a substantial argument that the standards of the code (including, e.g., right to refuse psychotropic medication absent emergency) apply under the Duran case to inmates who are committed to and under the jurisdiction of the Corrections Department.

Another recent legal development allows a persons to either plead guilty but mentally ill or be found by a jury of being guilty but mentally ill. This finding does not change the punishment consequences and it does not change the obligations of the Corrections Department concerning providing mental health care treatment. However, a guilty but mentally ill prisoner comes into the system with a judicial label that he is mentally ill. This judicial label

will have some effect on programming this individual by the Corrections Department. It creates a rebuttable presumption that when this person comes into the system he is in need of mental health care treatment. At the very least, I think there is a duty to inquire into such person's situation to see if he or she is at that time in need of any particular mental health care treatment.

These matters suggest a need to reexamine the question of whether or not the Corrections Department should operate its own treatment hospital for prisoners. Once a hospital is established, there would be a continuous funding supply which is a problem at present. This might avoid application of the mental health and developmental disabilities code, assuming legislation were passed to exempt prisoners from the obligations of the code as relates to providing mental health care treatment without informed consent. Prisoners' status and the overall responsibility for providing mental health care to prisoners would be clearer under this system. Furthermore, this would allow the Corrections Department to comply with the requirements of the Duran case with resources at its own disposal and it would also comply with the master plan recommendations for mental health care treatment, one of which was to provide a Forensic Hospital which would be contiguous to the planned institutional classification center. This would be a free-standing facility under the jurisdiction of the Corrections Department and it would basically complement the work of the Forensic Treatment Hospital and the department would be able to treat those individuals from the corrections system who become mentally ill while incarcerated and those coming into the system with the label of guilty but mentally ill.

There is much to be done in the field of mental health for prisoners. It is important to examine how legal decisions impact upon the total mental health care treatment system provided to prisoners and others who are incarcerated as we continue our planning and strategies for the future.

SUMMARY OF CONFERENCE DISCUSSION AND RECOMMENDATIONS

by

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The major focus of this conference was to "bring together decision makers in western state mental health and criminal justice systems to share information on issues and programs necessary to build more effective systems of care for mentally ill offenders."

The objectives of the conference were:

- To promote communication and information sharing between mental health and criminal justice professionals and administrators;
- To examine the advantages and disadvantages of different state systems for presentence evaluation, treatment, release and aftercare of mentally ill offenders;
- To examine what happens to persons found not guilty by reason of insanity in western state systems;
- To share information on recently enacted and proposed legislation affecting the mentally ill offender in western states; and
- To provide a framework for participants to examine their own state systems and request assistance from consultants and other states in planning or implementing changes.

Given the range of programs, issues, and problems that have been described and discussed at this conference, as well as the variety of approaches to their handling, it is very difficult to do justice to the many useful contributions and ideas that have been shared. Nor has there been the time to try to develop some overall framework within which the major points and recommendations could nicely be organized. Thus, what follows will simply be an effort to provide an overview of the major issues and themes, some recommendations that were either implicit or explicit, and some that I would suggest.

There is one initial caveat that should be stated. It is essential to keep in mind the present and particular circumstances and situation in each state (namely, the extant laws, political and organizational structures, key leaders in the systems of our concern, financing structures). The new approaches and ideas that have been shared from other states and those that one might wish to adapt to one's own jurisdiction will have to be funneled through the aforementioned organizational, political, administrative, and other structures and mechanisms. Thus one should try to consider the various

adjustments and adaptations that may well be necessary. By way of analogy, no matter how well designed is the carburetor on automobile A, it may simply not work too well--or even fit--cars of models B, C, and D. However, key features in the design and functioning of the element could well be adapted and used within other models. The focus then should be on the key features and principles that indeed have wide utility.

MAJOR PROBLEMS AND ISSUES IDENTIFIED AT THE CONFERENCE

- There are serious resource limitations in providing the range of services needed by mentally ill offenders in the mental health and criminal justice systems. Yet, despite such limitations (often very serious) the mandated mental health services are increasing.

- There are various political and public pressures for policies and programs that may not be well conceived, that do not consider the appropriate roles of mental health services, and which may not be cost-effective.

- Related to the above, all too often the public and political furor over the rare but dramatic cases tends to drive major policy and programmatic changes. The relatively infrequent instances of serious crimes committed by mentally ill offenders, and insanity acquittals in such cases, provide the most common examples.

- Despite the scarcity of existing mental health service delivery resources, these difficulties tend to be further compounded by inappropriate referrals and other misuses of available resources. (For example, sending criminal defendants to security hospitals or units for pretrial competency and related evaluations, instead of utilizing various outpatient options. Inappropriate referrals to security hospitals, or referrals that are required because of the absence of more appropriate service options, tend to create many problems; they also create pressures for increasing the number of security bed space.)

- In recent years most jurisdictions have experienced considerable public and political pressures pertaining to the handling and release of persons acquitted by reason of insanity. Because of understandable public fears of further "dangerous" acts, the hospitalization of such cases tends to extend well beyond the period of needed inpatient treatment.

- The relative absence of or general inadequacy of available mental health and related systems for postrelease monitoring, follow-up, and aftercare, results in longer-than-therapeutically indicated periods of hospitalization in security hopsitals and units.

- Concerns were expressed about the uses of the mental health systems for purposes of incarceration and social control of various "dangerous" persons. Such policies and practices tend to blur and confound the philosophical, ideological, and conceptual distinctions between state actions that are designed to be primarily therapeutic and those that are meant to exercise social control functions.

- The above philosophical and ideological issues also have implications for the role and functioning of mental health professionals. For example, in regard to the care and treatment of mentally ill offenders, who precisely is the primary client of the therapist--the patient, the facility, and/or the community?

Since this is not the place for any extended discussion of the various recommendations that were suggested by the speakers and the various participants, only a few specific points will be mentioned in what follows.

APPROACHES TO IMPROVING THE RESOURCE SITUATION

It must be accepted as a fact of sociopolitical reality that regardless of the exuberant and lofty rhetoric that is used in support of the parens patriae functions of the state (namely, to care for those who are unable to do so themselves--children, the mentally disabled, etc.), the actual allocation of resources will not match the rhetoric. The treatment needs of this group of clients (mentally ill offenders) are not likely to be viewed as priorities in the allocation of very scarce resources. Concerns about and resources for their secure confinement are typically of greater public concern. Thus, other approaches need actively to be explored for improving the resource situation.

- Agencies with close and even somewhat overlapping program concerns (e.g., corrections and mental health) need to work in closer cooperation and coordination of their efforts. The very limited mental health staff and related resources may well go farther if the agencies could work in greater cooperation. Requests for planned program extensions might receive better administrative and legislative response if joint planning and programming were conducted.

- Developing closer relationships with educational institutions (colleges and universities) located relatively near security hospitals and units and penal institutions should be attempted. Even in the absence of psychiatric residency rotations, clinical psychology internships, social work placements, graduate and even undergraduate students might be able to assist in a variety of roles. Certain research topics could well relate to agency needs while also providing material for term papers, theses or doctoral dissertations.

- The state chapters of the major mental health professional associations (psychiatry, psychology, social work, and nursing) have a number of public service activites and contributions. Assistance from these groups might be sought (on a pro bono basis) as part of the professional contributions to the community that are encouraged by these professional associations.

- Careful attention might be given to some of the current uses of mental health and related professional staff time to see if more effective and efficient uses might be possible. With regard to clinical psychologists, for example, is all the routine testing and evaluation that they are asked to do really necessary for some of the specific decisions that have to be made? Might more of their time be freed up for direct treatment services, for training of line staff, and related consultative roles?

THE NEED FOR A BROADER VIEW OF MENTAL HEALTH NEEDS AND RELATED PROBLEMS

This topic is a further extension of the first point mentioned above. As part of systematic planning for forensic services it is essential to view the health, mental health, and related service delivery systems in broad perspective. Changes made in one part of this interconnected system will have reverberations and consequences in other parts--typically the responsibility of other agencies. Alleviating a problem at one point in the process may possibly aggravate the problems at some other points. For example, it would be fair to say that some of the policy and programmatic dilemmas now being faced are related to major legal reforms over the past fifteen years--e.g., the requirement of durational limits on the postadjudication confinement of persons found to be incompetent to stand trial (Jackson v. Indiana, 1972) and those acquitted by reason of insanity. (For further details on these developments, see Shah, 1981.)

If the forensic services system is viewed in broader perspective, the interrelatedness of certain problems will become more evident and planning could be improved. Thus, as far as corrections and mental health are concerned within state governments, the overlapping responsibilities for mentally ill offenders requires greater coordination of effort and perhaps fewer applications of Jones' Law--that is, he who can smile when things are going wrong has thought of someone who can be blamed for it!

SOME ISSUES PERTAINING TO THE INSANITY DEFENSE

The public, political, and professional concern stimulated by this topic in the field of mental health law is entirely out of proportion to the very small numbers of cases involved. Yet, it is precisely because of the fundamental philosophical, moral, legal, and public policy questions imbedded in the notion of exculpatory insanity, as well as the dramatic nature of the rare

cases, that this topic demands the attention that it does. The most critical issue, it would appear, is not the precise wording of the insanity test or the considerable legal complexities involved. Rather, the major public concern appears to relate to the care, handling, and especially the release of such persons (those acquitted by reason of insanity).

Clearly, given the fundamental moral and philosophical values that underlie the insanity defense, in its uses over the past several decades this very narrow opening appears to have been widened. It is a matter of public policy determination as to the degree of restriction and narrowing of this opening that is needed. A variety of means can well be used for accomplishing the desired narrowing--some approaches are more likely to accomplish the desired goals than others that are being proposed.

The major problem for security hospitals and mental health professionals pertains to the treatment of insanity acquittees and, especially, with decisions pertaining to their release. The long-term and indefinite confinement in security hospitals of yesteryear is no longer legally permissible. Yet, release premised on predictions of "dangerousness" will continue to be problematic given the serious technical problems in trying to predict relatively rare events. From the standpoint of providing needed care and treatment to the patient, as well as realistic concerns about protecting the community, greatly improved programs for close follow-up, monitoring, outpatient treatment and aftercare are clearly needed. While the costs of such community-based services will be significant, they will be considerably lower than those associated with confinement in a security hospital.

With respect to this major issue and dilemma, careful study should be given to the approach being used in Oregon that was described by both Dr. Joseph Bloom and Jeffrey Rogers--that is, the Psychiatric Security Review Board (see also Bloom and Bloom, 1981; Rogers, 1982). Although the Oregon approach relates to specific enabling legislation and clearly receives priority attention in terms of resource allocations, the fundamental features of close and careful screening prior to release, and close monitoring and follow-up (with specifically assigned responsibility for such functions) in the community, could well be adapted in other jurisdictions. In short, I would venture the opinion that the answer to the public concerns is not in improved predictive technology for assessing "dangerousness," nor even in confinement in security hospitals for very long and expensive "warehousing." Rather, close monitoring, follow-up, and aftercare services during periods of conditional release are required. Such close follow-up provides the opportunities for continued assessments of progress as well as of developing problems (something that typically cannot be anticipated or predicted while the patient remains in the hospital); failure to follow the prescribed treatment regimen, deterioration in functioning, and other related problems can be determined with such close follow-up and appropriate interventions (including return to the hospital) utilized.

BALANCING OF THERAPEUTIC AND SOCIAL CONTROL OBJECTIVES

As several speakers at the conference pointed out, especially Dr. Lebegue, with regard to the confinement and treatment of mentally ill offenders the therapeutic functions do indeed overlap with the social control functions. Thus while there are appropriate concerns about persons being "sentenced" to mental hospitals (thereby raising questions as to the extent to which security mental hospitals are actually being used as "psychiatric prisons"), it must also be realized that the therapeutic and social control functions are not entirely distinct nor completely separate. Nor, for that matter, are the parens patriae and police power functions of the state entirely separate and distinct. However, the fundamental point, I believe, is that while recognizing the existence of some overlap in the above functions, it remains rather essential not to completely blur or to confound the philosophical, ideological, as well as related legal and policy distinctions.

Understandably, the particular balance that is drawn between the therapeutic and social control objectives will vary across jurisdictions to some slight degree, and there will also be variations over time. The fundamental dilemma here is of a kind that is, I believe, never solved. It is, rather, resolved in varying fashion and in the context of specific time periods, needs, and public perceptions.

Finally, it should be realized that changes and adjustments at one stage in the criminal and mental health process will have reverberations and consequences at various other places. For example, as civil commitments laws have been tightened and have increasingly been related to the criterion of "dangerousness" (to self or others), a number of very seriously ill persons will not meet this specific requirement. Thus while the rates of civil commitment have predictably dropped, in many jurisdictions the rates of criminal commitment have tended to increase (see, for example, Bonovitz and Bonovitz, 1981; Bonovitz and Guy, 1979; Dickey, 1980; Gudeman, 1981; Whitmer, 1980). Also, as more states move in the direction of adding a verdict of "guilty but mentally ill" to existing provisions (currently there are six such states but several others are also moving in this direction), increasing numbers of "mentally ill offenders" will be added to those needing or demanding mental health services. Such developments provide yet another major reason for closer planning and service delivery programs between the corrections, mental health, and related social service systems.

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SECTION II

WICHE SURVEY OF FORENSIC HOSPITALS IN WESTERN STATES

BACKGROUND

One of the problems faced by state mental health and corrections agencies in attempting to improve the quality and efficiency of services for the mentally ill offender is the lack of data on the extent of the problem and the number of mentally ill offenders currently being served by corrections and mental health systems in the different states. A further problem is lack of information on how different states are addressing problems of increases in court-ordered evaluations and treatment; pressures to eliminate or modify insanity defense laws and procedures to protect the community from dangerous offenders; treatment in hospitals and prisons; and provision of community aftercare for offenders who have completed their sentences but are still mentally ill. Participants at the conference pointed out that it is difficult to assess whether or not programs or ways of handling offenders that have been effective in one state would be effective in their states without better information on the laws and systems of care in the various states.

In order to begin to develop information that might be useful to the states in planning and assessing their own systems, WICHE conducted a survey of forensic hospital officials in the thirteen western states in May 1983. Preliminary discussion with state leaders quickly indicated that an all-inclusive study was beyond the resources of the states and WICHE staff for several reasons: the large number of questions needed merely to describe mentally ill offender systems; the relative lack of data; and the variations among state systems. Therefore, the survey was confined to gathering information on forensic hospitals with a few questions about alternatives to forensic hospitals that have been developed in the individual states. WICHE also requested that states submit copies of state statutes regarding the sanity defense, competency to stand trial, civil commitment, and other statutes particularly relevant to the MIO system. Although the questionnaire was sent to the states in advance, the survey was conducted by telephone in order to get as clear a picture as possible of the system and its many variations. Responses from three states--New Mexico, Utah, and Washington--were received too late to permit a telephone interview with the respondent.

The survey demonstrated both the magnitude of the problems faced by mental health and corrections personnel and the dedication and creativity of administrators and staff in developing strategies to improve systems of care. However, it also revealed that information systems to identify and track mentally ill offenders served in various aspects of the system are inadequate in most states. For example, no state was able to provide the number of offenders who plead not guilty by reason of insanity (NGRI) each year or the number of offenders who are evaluated or treated in the community. Arizona and Alaska could only estimate the number of different types of clients admitted to the forensic unit.

Extreme caution should be used in interpreting or attempting to compare statistics provided in the various tables by state. Statistics are only roughly comparable at best. On the other hand, it is important to begin to look at the data across states, to begin to find ways to make the data more comparable, and to share information among the states on programs and procedures which may improve the effectiveness and efficiency of mentally ill offender systems.

Results of the survey are presented in a series of tables listing data from each state, limited discussion of the data presented, a brief description of each state's system for dealing with mentally ill offenders, recent legislative or procedural changes affecting the system, and the most significant problems currently facing the state in dealing with MIOs. A list of the key respondent or respondents who provided the information from each of the states is included. Additional information about a state's MIO system may be secured from that individual. A copy of the questionnaire and transmittal letter is included at the end of this section.

FORENSIC HOSPITALS

Historically, in the western states mental health evaluation and treatment for mentally ill offenders have generally been provided in forensic hospitals or forensic units of state hospitals administered by state mental health agencies. Each of the thirteen states has a forensic hospital or forensic unit in the state hospital which is administered by the state mental health agency and provides some services to mentally ill offenders. In recent years, however, western states have begun to develop services outside the mental health forensic hospital. Alternatives include:

- Placing some evaluation and/or treatment services under the jurisdiction of the department of corrections;
- Providing for community-based or outpatient examinations for competency to stand trial or sanity examinations through the private sector or community mental health centers;
- Establishing specialized teams in the state mental health agency or department of corrections to screen offenders for further mental health examination or to conduct competency and insanity evaluations;
- Setting up community treatment or aftercare programs or community-based supervision of offenders as an alternative to inpatient treatment or to provide ongoing treatment for offenders no longer in need of inpatient care; and
- Developing or improving systems to provide mental health services to prison inmates.

Location and Administration of Forensic Facilities (Table 1)

Table 1 presents summary information on forensic facilities in the thirteen states including whether or not the facility is a separate hospital or unit of the state hospital, the administering state agency, the bed capacity, average daily census, budget, number of annual admissions, and number of staff. Further analysis of data summarized in Table 1 is presented in Tables 2-8.

Ten of the thirteen states have forensic units within their state hospitals. California has designated two state hospitals as forensic hospitals--Atascadero for maximum security and Patton for medium security offenders--and places minimum security penal code patients on general state hospital units at the Napa hospital. Nevada has a free-standing forensic facility--Lake's Crossing Center for the Mentally Disordered Offender. Arizona and Idaho have medium security forensic units at their state hospitals and maximum security units administered by the Department of Corrections. Alaska has recently opened a forensic evaluation center at one of its correctional facilities, but continues treatment of penal code commitments at the Alaska Psychiatric Institute. Alaska plans to develop a free-standing forensic facility or a forensic unit within a correctional facility, which will eventually handle all penal code examinations and commitments for treatment.

State forensic facilities are administered by the state mental health agency in ten of the thirteen western states. Exceptions are Arizona and Idaho, in which mental health and corrections agencies share responsibility for examination and treatment of penal code commitments, and Wyoming, in which the Board of Charities and Reform administers the state hospital. In addition, each of the states provides some level of mental health care to prison inmates, which is administered by the state corrections agency.

Cost of Forensic Facility Services (Table 2)

Table 2 displays information on costs per patient-day, costs per bed, and costs per admission. This table should be viewed with considerable caution as current annual budget figures in the different states are not comparable. Although states were asked to identify types of costs included in budget figures, the request was not specific enough to ensure comparability. The table attempts to identify those states which included personnel and associated costs only versus those which also included costs for food service, building and grounds maintenance, and administrative overhead. However, exactly which costs are included or excluded in the budget figures are not entirely clear.

Another problem in comparing figures is that some states provided budget and admission figures for calendar 1982, some for fiscal 1982, and some did not identify the year used. Only a few states identified whether or not average daily census figures represented the census on a given day or were an average for the year.

The costs presented are arbitary figures derived by dividing total budgets by average daily attendance, bed capacity, or annual admissions. Daily costs are derived by dividing annual costs by 365. Actual per day costs charged by

TABLE 1

SUMMARY INFORMATION ON FORENSIC HOSPITALS IN THIRTEEN WESTERN STATES
1981 - 1982

	Separate Forensic Hospital	Forensic Unit in State Hosp.	State Adminis. Agency	Bed Capacity	Average Daily Census	Annual Budget	Annual Admissions	Number of Staff	
ALASKA	Highland Unit		MH	10	10	*$1,097,000	225	17	*Note:* Annual admissions to Highland Unit are estimated. Data on annual admissions, budget, and staff are not available for forensic units at Alaska Psychiatric Institute.
		API	MH	36	36+	N/A	N/A	N/A	
ARIZONA		State Hosp. Unit	MH-Medium	24	35	*$1,366,600	99	57.5	
	Alhambra Unit		OOC-Maximum	40**	30-35	N/A	122	26+ security pers.	
CALIFORNIA	Atascadero		MH	973	980	$40,000,000	1425	1272	*Note:* Forensic patients at Napa are mixed throughout hospital with civilly committed patients. Therefore, cannot identify bed capacity and staff. Annual admissions do not include civil patients admitted to forensic units.
	Patton		MH	668	933	$37,000,000		1419	
	Napa		MH	1693	270	$11,000,000		N/A	
COLORADO		X	MH	350	357	*$9,010,000	486	315	
HAWAII		X	MH	83	81	*$1,441,186	274	86	*Note:* An additional 25 forensic patients were housed on other units in the hospital on 2/7/83 (3 unfit and 22 NGRI (16 felons and 9 misdemeanants).
IDAHO		State Hosp. Unit	MH-Medium	20	19	$ 385,000	15	22.9	
		Prison Unit	OOC-Maximum	13	13	$ 356,480	N/A	N/A	*Note:* Data on annual admissions and staff are not available for prison unit.
MONTANA		X	MH	75	66	*$1,365,945	265	67	
NEVADA	X		MH	32	24.6	$1,330,188	115	43	
NEW MEXICO	X		MH	90	78	$2,993,600	150	142	*Note:* Budget, ADA, and bed capacity include specialized 30-bed unit for prison inmates which was operational July 1, 1982, through February 1983.
OREGON		X	MH	180	181	$4,146,000	383	125	*Note:* Does not include treatment units located at state hospital but funded by Department of Corrections.
UTAH		X	MH	88	91	*$1,350,987	172	85.7	
WASHINGTON		Eastern State Hosp.	MH	115	132	$1,887,888	443	81.7	*Note:* Annual budget for Western State Hospital was derived by multiplying per patient day cost x ADA x 365.
		Western State Hosp.	MH	408	400	$10,801,430	897	240.5	
WYOMING		X	Board of Charities & Reform	45	43	N/A	299	74	*Note:* Forensic units are not budgeted separately from state hospital budget.

* Budget does not include food service, building and grounds maintenance, administration overhead.
** Includes only the mental health treatment unit. Total capacity of Alhambra Unit is 147 and average daily census, 200+.

TABLE 2

COST OF FORENSIC FACILITY SERVICES IN THIRTEEN WESTERN STATES
1981-1982

(Annual costs are derived by dividing annual budget by 1) Average daily attendance, 2) bed capacity, 3) annual admissions. Daily costs derived by dividing annual cost by 365.)

	Forensic Facility	Total Budget	(1) Average Cost Per Resident Patient		(2) Average Cost Per Forensic Bed		(3) Average Cost Per Annual Admission
			Annual Cost	Cost Per Patient Day	Annual Cost	Daily Cost	
ALASKA	Highland Unit Only	$ 1,097,000*	$83,000	$ 227.40	$83,000	$227.40	$ 4,876
ARIZONA	State Hospital Unit Only	$ 1,366,600*	$39,046	$ 106.98	$56,942	$156.00	$13,804
CALIFORNIA	Forensic Program at Atascadero, Patton, and Napa	$88,000,000	$40,311	$ 110.44	$26,395	$ 72.31	$61,754
COLORADO	Colorado State Hospital Units	$ 9,010,000*	$25,452	$ 69.73	$25,743	$ 70.53	$18,539
HAWAII	Hawaii State Hospital Units	$ 1,441,186*	$17,792	$ 48.75	$17,364	$ 47.57	$ 5,260
IDAHO	State Hospital Unit Only	$ 385,000*	$20,263	$ 55.51	$19,250	$ 52.74	$25,667
MONTANA	Montana State Hospital Units	$ 1,365,945	$20,696	$ 56.70	$18,213	$ 49.90	$ 5,155
NEVADA	Lake's Crossing Unit	$ 1,330,188	$54,051	$ 148.08	$41,568	$113.89	$11,567
NEW MEXICO	New Mexico Forensic Hospital	$ 2,993,600	$38,379	$ 105.15	$33,262	$ 91.11	$19,957
OREGON	Oregon State Hospital Units	$ 4,146,000	$22,906	$ 62.76	$23,033	$ 63.11	$10,825
UTAH	Utah State Hospital Units	$ 1,350,987*	$14,846	$ 40.67	$15,352	$ 42.06	$ 7,855
WASHINGTON	Eastern and Western State Hospital Units	$12,689,318	$23,852	$ 65.35	$24,263	$ 66.47	$ 9,470
WYOMING	Wyoming State Hospital Units	N/A	N/A	N/A	N/A	N/A	N/A

* Budget does not include food service, building and grounds maintenance, and administrative overhead.

facilities are somewhat higher, e.g., Colorado's per day charge is $127; Utah's $150; Idaho's $80, etc.

Despite these problems, a few observations may be made about costs in different states. Costs per patient-day and costs per admission tend to be higher in programs in which most patients are admitted for treatment only rather than evaluation and treatment. The four states in which all or most evaluations are done in the community--Arizona, California, New Mexico, and Nevada--have relatively high per patient-day costs and per patient-admission costs. On the other hand, Alaska has the highest per patient-day cost for its newly organized unit, which, at the present time, provides evaluation services exclusively. This seems to be due to the small size of the unit--ten beds--and the need to hire sufficient highly qualified personnel to conduct a high volume of court-ordered evaluations.

It should be noted that the budgets of programs with the lowest per patient-day costs--Hawaii, Idaho State Hospital Unit, Montana, and Utah--do not include all costs of patient care.

Forensic Hospital Units

Table 3 presents information on the type of treatment units in forensic facilities and average daily census in each unit. All states except Alaska, Nevada, and Washington have developed treatment units on some type of security continuum. Decisions about treatment programs and assignment of offenders to units are based on the level of security required by the patients' behavior. Ten states have maximum and medium security units. California, Colorado, and Hawaii also have minimum security units and Colorado an intermediate unit. Hawaii also maintains approximately twenty-five psychiatric rehabilitation beds in other hospital units for forensic patients who would benefit from long-term specialized treatment. The other states generally place penal code patients who do not require "secure treatment" on other wards of the hospital with civilly committed or voluntary patients, according to their treatment needs.

Programs for offenders requiring maximum security are administered by the Department of Corrections in Arizona and Idaho. In 1978, the building serving forensic patients at the state hospital in Arizona was turned over to the Department of Corrections. This building is now used as an evaluation and reception center for classification and determination of prison assignment for all convicted offenders. Average daily census is more than 200. It also has a forty-bed unit for evaluation and treatment of mentally ill offenders requiring maximum security. In Idaho, a thirteen-bed unit located at the state prison provides evaluation and treatment services for mentally ill offenders requiring maximum security. In California the 973-bed Atascadero state hospital is the forensic hospital for maximum security offenders. The 668-beds at Patton State Hospital will be expanded to 1,084 in fiscal 1983 to serve medium security patients. Most minimum security offenders--270 in 1982--are served at Napa State Hospital, although some are placed in other state hospitals, according to their treatment needs.

Utah and Oregon have specific units for treatment of sexual offenders in addition to maximum and medium security units. New Mexico has had a special

TABLE 3

AVERAGE DAILY CENSUS AT FORENSIC FACILITY UNITS IN THIRTEEN WESTERN STATES
1981-1982

	Maximum Security	Medium Security	Inter-mediate Security	Minimum Security	Other Types of Units: Sexual Offender	Prisoner Unit	Psych. Security Unit	NGRI Treatment Unit	Highland Evaluation Unit	MIO Program	Competency Evaluation and Treatment	Exceptional Residence Program	Total ADA in Forensic Hospital
ALASKA							14	22	10				46
ARIZONA	30-35	35											65-70
CALIFORNIA	980	933		270									2183
COLORADO	133	120	42	62									357
HAWAII	24	26		31								25	106
IDAHO	13 prison unit	19 S.H. So.											32
MONTANA	2 units 39	2 units 27											66
NEVAOA	only	one	unit										24.6
NEW MEXICO	8*	52*				30*							78
OREGON	2 units 60 *	3 units 90 *			30 *								181
UTAH	36	28			27								91
WASHINGTON	Eastern State Hospital Western State Hospital				45 192					42 208	24	21	132 400
WYOMING	28	15											43

* Bed capacity. ADA for units not available.

unit for treatment of prison inmates traumatized by the prison riot in 1980. This unit was phased out in February 1983.

Nevada has only one thirty-two-bed medium security treatment unit in its forensic program at Lake's Crossing Center. Idaho has a nineteen-bed medium security unit at State Hospital South. Alaska has two units at the Alaska Psychiatric Institute (the state hospital). One provides secure treatment for twenty-two offenders found not guilty by reason of insanity (an additional six NGRIs are treated in the general population at API). A fourteen-bed psychiatric security unit at API provides treatment for civilly committed patients who need a secure setting, treatment to restore competency, and treatment of offenders transferred from jails or correctional facilities. The ten-bed Forensic Treatment and Evaluation Services Program temporarily located at Highland Mountain Correctional Center was opened in October 1982. The program has assumed responsibility for all court-ordered evaluations and will eventually provide all forensic evaluation and treatment services for the state.

The two Washington hospitals organize treatment units by commitment status and individualized treatment needs. Western State Hospital handles all patients requiring maximum security arrangements. Both hospitals provide for evaluation and treatment of medium security patients. A large proportion of forensic beds--forty-three at Eastern and 198 at Western State Hospital--are devoted exclusively to sexual offenders. Western's mentally ill offender program includes an evaluation unit, inpatient treatment, and a community program. Eastern has three units in addition to the sexual offender unit. An eighteen-bed unit provides fifteen-day observation and examination for court-ordered evaluations of competency to stand trial; a twenty-bed Exceptional Residents Program provides long-term treatment for chronically mentally ill insanity commitments; and a thirty-four-bed unit houses the higher functioning offenders committed for criminal insanity.

Staff in Forensic Facilities (Table 4)

Table 4 presents information on staffing patterns in forensic facilities by discipline. As not all states were able to identify staffing patterns by unit, the table presents total staff for the forensic facilities. Except for California and New Mexico, staff listed by the respondents include only treatment-related staff plus administrative and clerical support. Staff-per-resident-patient ratio is derived by dividing number of staff by average daily census.

Except for Alaska, higher ratios of staff per resident patient occur in programs which report all support staff (California, Nevada, and Wyoming) or programs which provide primarily treatment services (Arizona, California, Nevada, New Mexico). Alaska's staffing pattern includes a much higher proportion of graduate-level mental health personnel than other programs in the region.

Types of Patients Served at Forensic Facilities (Table 5)

One of the frustrations of state administrators in trying to compare clients served by forensic facilities in different states has been the lack

TABLE 4

STAFF IN FORENSIC FACILITIES BY DISCIPLINE AND
STAFF TO CLIENT RATIO IN THIRTEEN WESTERN STATES
1981-1982

	Psychiatrists and Physicians	Ph.D. Psychol.	M.A. Psychol.	M.S.W. S.W.	M.A. Psych. Nurses	RNs	LPNs	Psych. Techs.	Security Guards	Admin.	Support Staff	Other	Total Staff	Average Daily Census	Staff per Resident Patient
ALASKA	Highland Unit Only 3	2		2		5		5		1	2	7	17	10	1.7
ARIZONA	State Hospital Unit Only 1	2	2	3	0	7	2	31.5		1	2	6	57.5	35	1.6
CALIFORNIA	45	34 ⌣		54	113 ⌣			1144	176		1125		2691	1913	1.4
COLORADO	8	9	1	9		38	1	174	32	12	14	17	315	357	.9
HAWAII	2.5	1.5		3		21	12	41			3	2	86	81	1.1
IDAHO	State Hospital Unit Only .3	.5	0	1.5	0	1	3	10	.3	.3	5	1	22.9	19	1.2
MONTANA	1	2		1		2	8	49		2		2	67	66	1.0
NEVADA	1	2		2	2	0	5	23	1	1	5	1	43	24.6	1.7
NEW MEXICO	1	1	4	5	0	1	15	76	8	7	24		142	78	1.8
OREGON	5	3	0	5	1	11	0	95 Psych. Sec. Aides		3	2		125	181	.7
UTAH	1	2	1	6	0	10.6	6.1	55		4			85.7	91	.9
WASHINGTON	8.7	8	0	2	0	37.5	82	132		7	18	27	322.2	532	.6
WYOMING	1	part time		3		1	3	29	25	2	10		74	43	1.7

TABLE 5

NUMBER AND TYPES OF ANNUAL ADMISSIONS TO FORENSIC FACILITIES IN THIRTEEN WESTERN STATES
1981-1982

	ADMISSION FOR EVALUATION ONLY					ADMISSIONS FOR TREATMENT									
	Competency to Stand Trial	NGRI or GPMI	Convicted Offender Pre-sentence	Other	Total Eval. Only	Restore Competency	Indiv. Found NGRI	Indiv. Found GBMI	Prison Transfer	Other Instit. Transfer	Sexual Offender	Civil Commit. or Volun.	Other	Total Treatment	TOTAL ALL ADMISSIONS
ALASKA*					225										225
ARIZONA*	MH 3 DOC 9		5		3 14	12 15			93			84		96 108	99 122
CALIFORNIA	EVALUATION DONE AT COUNTY LEVEL					725	228		103		369	N/A		1425**	1425**
COLORADO	103	70	9	155	337	69	27		27		5	20	1	149	486
HAWAII	186	40	4	3	233	15	18		2	1	(17) (inc. in other col)	1	4	41	274
IDAHO	0	0	0	0	0	0	6		0	4		5		15	15
MONTANA	94				94	24 total (includes sexual offenders)			20		(included in other col)	127		171	265
NEVADA	EVALUATION DONE IN COMMUNITY					69	2		6			38		115	115
NEW MEXICO	26	0	15	3	44	29	0	1	43	0	22	1	10	106	150
OREGON	96	22	4	49	171	67	109	-	3	10	11	12		212	383
UTAH	2	2	83	15	102	3	2		25		40			70	172
WASHINGTON	E 168 W 428	149			317 428	48 171	32 141			2	46 155			126 469	443 897
WYOMING	63			16	79	1	3	-	17	-	22	177		220	299

* Estimated FY 1982
** Does not include admissions of civil patients to forensic hospitals

of information on the types of clients admitted, the purpose of the admission, and the makeup of the resident population the facility must deal with. In some states, statutes and tradition require that all or most court-ordered penal code examinations be conducted in the forensic facility; in others, all or most examinations are conducted in the community and only those in need of mental health treatment are hospitalized. Some states use their forensic facilities for treatment of civilly committed or voluntary patients from the general hospital population who need a secure treatment setting; others confine admissions to penal code commitments only. In some states, prison inmates who require intensive mental health treatment are transferred to state hospital forensic facilities; in others all prison inmates are treated in prison mental health programs or programs administered by the Department of Corrections and transfer to state hospital facilities may actually be prohibited. Some states have a fairly high volume of examinations and/or commitments for treatment under the state's NGRI statute; others have few or none. Tables 5-8 present information on the types of clients served in forensic facilities in the different states.

Table 5 presents raw data on admissions by category for each state in either fiscal or calendar 1982. WICHE's questionnaire requested data on two general types of admissions: those admitted for evaluation only and those admitted for treatment. The evaluation category includes court-ordered examinations for competency to stand trial, examinations required by the insanity defense law, and examinations of convicted offenders to determine disposition. In most cases these offenders would not be admitted for treatment without further court action. The treatment category includes patients who are committed by the courts or transferred through administrative mechanisms for treatment of their mental illness. Although evaluation of the patient's mental status and treatment needs is conducted for most patients, the primary purpose of the admission is treatment of his/her mental illness, not evaluation of whether or not the patient is mentally ill.

In the evaluation-only category, Colorado, Hawaii, Utah, and Washington admit a substantial proportion of total admissions for evaluation only; whereas Arizona, California, Idaho, and Nevada admit no or very few offenders for evaluation only. Although in most states evaluation-only admissions are primarily evaluations for competency to stand trial or a combination of competency to stand trial and not guilty by reason of insanity, Utah provides a substantial number of presentence evaluations of convicted offenders and Colorado's forensic program provides civil commitment evaluations for individuals who also have criminal charges pending.

In the treatment category, Hawaii, Utah, and Wyoming admit few patients to restore competency to stand trial; whereas in California and Nevada a substantial proportion of admissions are restoration of competency clients. Only California, Colorado, Hawaii, Oregon, and Washington have more than six annual commitments of individuals found not guilty by reason of insanity. Arizona and the three smaller states--Montana, Nevada, and Wyoming--are the only programs in which all civilly committed or voluntary patients who require a secure treatment setting are treated in the forensic units. All other states except Utah and Washington, which admit only penal code patients, may occasionally admit civil patients.

The other large population which is handled differently by the various states is the sexual offender population. Oregon, Utah, and Washington provide separate units for sexual offenders and a fairly high proportion of admissions are sexual offenders. California also currently has a high proportion of sexual offender admissions but recent legislation will send sexual offenders to prison rather than to the mental health forensic program. California has an arrangement with the Department of Corrections to fill beds vacated by sexual offenders with prison inmates in need of intensive mental health treatment. Colorado, Hawaii, Montana, New Mexico, and Wyoming laws permit treatment of sexual offenders at forensic units, but numbers of admissions are small. Arizona, Idaho, and Nevada do not admit sexual offenders to forensic programs, and Colorado is phasing out its sexual offender treatment program.

Table 6 presents the same data as Table 5 in the form of types of admission as a percentage of total admissions. Table 7 attempts to enhance the comparability of census and admission data by converting data to daily census and annual admissions per 100,000 population.

Comparison of Admissions and Average Daily Census (Table 8)

Data on types of admissions to forensic facilities does not, of course, provide a complete picture of the types of offender populations on which different state systems are expending their resources. We had hoped to be able to compare the number of annual admissions of a given type of client, e.g., NGRI, with the number in the census at a given point in time. This would provide some information on lengths of stay and the types of clients which may be overburdening the system. However, few states were able to provide average daily census data by type of admission.

Table 8 provides information from three states--California, Colorado, and Hawaii--that were able to provide the census data. As expected, the data shows that while Colorado has over twice as many, and Hawaii almost six times as many, admissions for evaluation only as for treatment, the majority of patients on forensic units on any one day are treatment patients (41 to 33 in Hawaii; 333 to 19.7 in Colorado). Therefore, even with the relatively large number of court-ordered evaluations in those forensic programs, the bulk of forensic resources are being expended for treatment of various types of mentally ill offenders. An examination of data on types of treatment admissions in the three states indicates that while the number of annual admissions of NGRI offenders is relatively small, the long lengths of stay are resulting in progressively larger numbers of NGRIs in the forensic census. Colorado, for instance, admitted only twenty-seven NGRIs in 1982, but 218 were in the average daily census. Figures for California are 228 and 955, and for Hawaii 18 and 28. A somewhat similar relationship obtains between admissions and average daily attendance for sexual offenders--369 admitted and 1,077 in the daily census for California and five admitted and twelve in the daily census in Colorado. (However, this relationship may be partly due to the fact that both states are attempting to phase out treatment of sex offenders in their forensic facilities.) Data for the three states on patients admitted for treatment to restore competency reveals the reverse relationship--more admissions than patients in the daily census--indicating a shorter average length of stay.

TABLE 6 TYPES OF ANNUAL ADMISSIONS TO FORENSIC FACILITIES AS % OF TOTAL ADMISSIONS IN THIRTEEN WESTERN STATES 1981-1982

	Total admissions	ADMISSION FOR EVALUATION ONLY				Total evaluation only	ADMISSIONS FOR TREATMENT							Total treatment
		Comp. to stand trial	NGRI or GBMI	Convic. offen. pre-sentence	Other		Restore competency	NGRI or GBMI	Prison transfers	Other instit. transfers	Sexual offenders	Civil commit. or volun.	Other	
ALASKA	225					100%								
ARIZONA	221	5%	2.3%			7.7%	12.2%	0	42.1%			38%		92.3%
CALIFORNIA	1425					0%	50.9%	16%	7.2%		25.9%			100%
COLORADO	486	21.2%	14.4%	1.9%	31.9%	69.3%	14.2%	5.6%	5.6%		1.0%	4.1%	.2%	30.7%
HAWAII	274	67.9%	14.6%	1.4%	1.17%	85.0%	5.5%	6.6%	.7%	.4%	.4%	.4%	1.1%	15.0%
IDAHO	15					0%		40%		26.7%		33.3%		100%
MONTANA	265	35.5%				35.5%	9.1%		7.5%		47.9%			64.5%
NEVADA	115					0%	60%	1.7%	5.2%			33.1%		100%
NEW MEXICO	150	17.3%		10%	2%	29.3%	19.3%	.7%	28.7%		14.7%	.7%	6.7%	70.7%
OREGON	383	25.1%	5.7%	1.0%	12.8%	44.6%	17.5%	28.5%	.8%	2.6%	2.9%	3.1%		55.4%
UTAH	172	1.2%	1.2%	48.2%	8.7%	59.3%	1.7%	1.2%	14.5%		23.3%			40.7%
WASHINGTON	1340	55.6%				55.6%	16.3%	12.9%		.2%	15%			44.4
WYOMING	299	21.0%			5.4%	26.4%	.3%	1.0%	5.7%		7.4%	59.2%		73.6%

TABLE 7

RESIDENT PATIENTS AND ADMISSIONS TO FORENSIC FACILITIES PER 100,000 POPULATION IN THIRTEEN WESTERN STATES
1981-1982

	State Population 1980 Census	Average Daily Census per 100,000 Population	ANNUAL AOMISSIONS PER 100,000 POPULATIONS							
			Total Admissions	Admissions Evaluation Only	Admissions for Treatment	NGRI or GBMI Admissions	Admissions to Restore Competency	Prison Transfers	Transfers of Civil Pts. from Other S.H. Units	Sex Offender
ALASKA	400,000	11.5	56.3	56.3	N/A					
ARIZONA	2,718,000	2.6	8.1	.6	7.5	0	1.0	3.4	3.1	0
CALIFORNIA	23,669,000	9.2	6.0	0	6.0	1.0	3.1	.4	N/A	1.6
COLORADO	2,889,000	12.3	16.8	11.7	5.2	.9	2.4	.9	.7	.2
HAWAII	965,000	8.4	28.3	24.2	4.3	1.9	1.6	.2	.1	1.8
IDAHO	944,000	2.0	1.6	0	1.6	.6	0	.4	.5	
MONTANA	787,000	8.4	33.7	11.9	21.7	3.1		2.5	16.1	
NEVAOA	799,000	3.1	14.4	0	14.4	.3	8.6	0	4.8	
NEW MEXICO	1,300,000	6.0	11.5	3.4	8.2	.08	2.2	3.3	.08	1.7
OREGON	2,633,000	6.9	14.6	6.5	8.1	4.1	2.5	.1	.5	.4
UTAH	1,461,000	6.2	11.8	7.0	4.8	.14	.2	1.7	0	2.7
WASHINGTON	4,130,000	12.9	32.4	18.0	14.4	4.2	5.3	0	0	4.9
WYOMING	471,000	9.2	63.5	16.8	46.7	.6	.2	3.6	37.6	4.7

TABLE 8 COMPARISON ADMISSIONS AND AVERAGE DAILY CENSUS AT FORENSIC FACILITIES BY TYPE OF PATIENT
CALIFORNIA, COLORADO, HAWAII
1981-1982

	CALIFORNIA		COLORADO		HAWAII	
	1) No. Annual Admissions	3) ADA	1) No. Annual Admissions	4) ADA	2) No. Annual Admissions	5) ADA
EVALUATION ONLY						
Individual evaluation for competency			103	5.8	186	27
Individual evaluation for NGRI or GBMI			70	4.3	40	3
Convicted offender pre-sentence evaluation			9	<1.0	4	1
Transfers from prison for evaluation only					1	0
Other evaluation			148 7	7.6 <1.0	2	2
TOTAL EVALUATION ONLY			337	19.7	233	33
TREATMENT						
Treatment to restore competency	725	550	69	41	15	13
Individual found NGRI	228	955	27	218	18	28
Prison transfers for treatment	103	60	27	25	2	0
Transfers other institutions for treatment						
Sexual offenders	369	1077	5	12	included in other categories	
Transfers of civilly committed or voluntary patients from other hospital units	N/A	80	20	36	1 or 2	0
Other treatment			1	1	4	-
TOTAL TREATMENT	1425	2722	149	333	40	41
TOTAL ALL	1425	2722	486	352.7	274	74

1) Annual admissions during fiscal 1982
2) Annual admissions during calendar 1982
3) Census on January 1, 1982
4) For evaluation categories census is average per fiscal 1982; for treatment categories census is on 12/31/82
5) Census on 2/14/83

THE INSANITY DEFENSE

The insanity defense has always been a controversial law that in the public's mind allows criminals to avoid responsibility for their acts and releases dangerously mentally ill individuals to prey on helpless individuals in the community. The attempted assassination of President Reagan and tragedies in Alaska and Arizona and, perhaps, other states have reinforced this view and resulted in introduction of legislation to make changes in insanity defense laws in almost all of the WICHE states. This in spite of the fact that the number of successful insanity pleas are extremely low in most of the states. Although the volume of legislation proposing changes in the states' laws is higher this year due to these recent events, insanity defense and related laws have been undergoing substantial revision in the western states over the past four or five years.

Incompetence to Stand Trial

Each of the western states, as part of the insanity defense law or separate legislation, has statutory provisions for evaluation of an offender's "competence to stand trial" or "fitness to proceed to trial." These statutes require that a defendant must have the capacity to understand the charges filed and to cooperate (or assist) in his/her own defense. Impact of these laws on the forensic system are in two areas: 1) evaluation of a defendant's competency to stand trial when requested or ordered by the court and 2) provision of treatment to restore competency when ordered by the court.

In the western states, competency examinations may be conducted in the forensic facility or the community (usually the jail), except in Wyoming, which requires examination in the forensic unit at the state hospital. However, in practice states vary widely as to whether examinations are conducted in the community or the forensic facility or some combination of the two. In Alaska, Colorado, Hawaii, and Montana most or all competency examinations are done at the forensic facility; in Arizona, California, Idaho, Nevada, and Utah, most or all examinations are done in the community. In New Mexico and Oregon the majority of evaluations are done in the community but some in the forensic facility.

One factor that seems to affect the number of evaluations (both competency and sanity examinations) done in the community is who pays for the examination. For example, in Oregon the court must pay $460 plus daily hospital charges and in Utah counties are charged $150 per day for evaluations in the forensic unit, which tends to reduce the number of hospital evaluations. On the other hand, in Montana all evaluations conducted in the forensic hospital are at state expense while community evaluations must be purchased by the court, which tends to increase hospital evaluations.

Treatment to restore competency is provided almost exclusively by forensic facilities in all states but New Mexico, although about half of the states have statutory provisions allowing community treatment if so ordered by the court. The number and percentage of total admissions of individuals admitted for treatment to restore competency vary significantly among the states.

Hawaii, Utah, and Wyoming have very low rates of admission (.3 percent to 5.5 percent); California and Nevada have high rates (50.9 percent to 60 percent) and the other states lie somewhere in between (12.2 percent to 19.3 percent). Reasons for the extreme variation may lie in how the states handle examinations for competency to stand trial. For instance, Hawaii finds that many individuals committed for evaluation of competency may be restored to competency by administration of medication and a short-term treatment regimen during the evaluation process. In a number of states, if a person is found incompetent to stand trial and is not dangerous, the court may drop criminal charges in exchange for an agreement to seek appropriate treatment or may institute civil commitment proceedings. It should be noted that the two states with highest rates of admission--California and Nevada--are states in which evaluation is done at the community level--most often while the defendant is in jail--and no opportunity for treatment occurs during the evaluation period. Table 10 presents information on the proportion of competency evaluation and treatment services provided in forensic facilities versus the community in the thirteen states.

Several states recently have enacted or are considering legislation to limit the length of commitment of offenders found incompetent to stand trial. These actions are in response to Jackson vs. Indiana, which ruled that prolonged and indeterminate commitment violated due process rights of pretrial incompetents.

The Insanity Plea (Table 9)

Table 9 presents information on the insanity plea in the thirteen states including the type of insanity plea, the standard or criteria for determination of insanity, whether the burden of proof is on the prosecution or defense, the number of admissions of NGRI to forensic facilities, the number of insanity defendants in treatment at the forensic hospital, and recently enacted or proposed legislation affecting the insanity defense in each state.

All states except Idaho and Montana have statutes allowing a criminal defendant to plead not guilty (in Oregon "not responsible") by reason of insanity or mental illness. Three of these states--Alaska, New Mexico, and Utah--have added a plea of "guilty but mentally ill" to their insanity defense law. Idaho and Montana technically have eliminated the NGRI plea but both retain the *mens rea* provision that an offender may be found not guilty for the reason that due to mental disease or defect he/she could not have a particular state of mind that is an essential element of the offense charged.

The criteria or tests used for determining insanity is the American Law Institute (ALI) test or the M'Naghten test. The ALI test provides that the defendant is not criminally responsible if at the time of the criminal conduct as a result of mental disease or defect the defendant lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law. The M'Naghten test provides that a defendant is not criminally responsible if the defendant does not know the nature and quality of the act or does not know the act is wrong.

Four states--Hawaii, Oregon, Utah, and Wyoming--use the ALI test. Five other states--Arizona, California, Colorado, Nevada, and Washington--use the M'Naghten test. The state of New Mexico adds an "irresistible Impulse" test to the M'Naghten rule. Alaska's new insanity defense statute retains the ALI test for the guilty but mentally ill plea but provides the M'Naghten test for NGRI pleas. Idaho retains the ALI criteria for determining insanity of convicted offenders eligible for mental health treatment.

Once the insanity plea is raised, the burden of proving the defendant sane beyond a reasonable doubt is placed on the prosecution in three states--Colorado, Utah, and Wyoming. In the remaining states the defense must prove insanity by a preponderance of evidence.

The number of NGRI committed to the forensic facilities in the western states in 1982 approaches but does not equal the number of successful insanity pleas in 1982, a figure which is not available in the states surveyed. In Arizona, for instance, an individual found not guilty by reason of insanity cannot be committed except through civil proceedings. Other states require commitment if the individual is dangerous or likely to commit additional felonies.

The last column in Table 9 lists legislation enacted in the 1982 or 1983 legislative sessions or introduced in the 1983 session. Significant revisions of insanity defense laws were enacted in Alaska, Idaho, and New Mexico in 1982 and in Utah in 1983. Hawaii enacted legislation in 1982 and has introduced additional bills in the 1983 legislative session to carry out recommendations of the Governor's Crime Commission, which reported its findings and recommendations regarding revisions to the insanity defense law in 1982. Most other states have introduced legislation affecting the insanity defense law during the 1983 session. The majority of bills introduced would restrict criteria for a finding of insanity or provide more controls on release of MIOs to the community.

COMMUNITY PROGRAMS FOR MENTALLY ILL OFFENDERS

Table 10 presents limited information on the proportion of evaluation and treatment services for competency to stand trial and NGRI defendants provided in the community versus the forensic facility. Except for California, which compiles statistics on MIOs evaluated and treated in the community as well as in the forensic facilities, the percentages of MIOs served in the community versus the hospital are estimates provided by questionnaire respondents. The material presented on community evaluation of competency to stand trial and treatment to restore competency was discussed in the previous section.

Five states--Alaska, Arizona, Nevada, New Mexico, and Wyoming--do not have statutory provisions allowing conditional release of individuals committed as NGRI. Utah adopted a conditional release provision as part of its 1983 revision of its insanity defense law. In most states which allow conditional release, the court determines conditions and authorizes release based on recommendations of the forensic facility. In Oregon the Psychiatric Security Review Board (PSRB) and in Utah the Board of Pardons authorizes release.

TABLE 9

STATUS OF INSANITY DEFENSE IN THIRTEEN WESTERN STATES, 1983

	Type of Insanity			Type of Insanity Test	Burden of Proof on Defense or Prosecution	No. of NGRI in 1982		Recent or Proposed Legislation
	NGRI	GBMI	Other			Admitted to Forensic Facility	ADA in Forensic Facility	
ALASKA	X	X		M'Naghten for NGI ALI for GBMI		N/A	28	Legislation passed in 1982 - 1) Added guilty but mentally ill plea and restricted criteria for determining NGRI. 2) As a result of class action suit, funds provided to increase mental health services in jails.
ARIZONA	X			M'Naghten	defense	1 or 2	1 or 2	Proposed legislation 1983 - 1) Move burden of proof of insanity from prosecution to defense, provide mandatory hospitalization if found NGRI, require authorization from court prior to discharge. 2) Expand definition of dangerousness. 3) Provide for conditional release. 4) Allow transfers of prisoners to state hospital.
CALIFORNIA	X			M'Naghten	defense	228	955	Proposed legislation 1983 - 1) Form of GBMI in which convicted would be sent to prison for 30 days, then transferred to st. hosp. treatment until no longer mentally ill. 2) Change insanity plea from NGRI to GBMI but no substantive changes in criteria or procedures in current NGRI law.
COLORADO	X			M'Naghten plus irresistible impulse	prosecution	27	218	Legislation passed 1982 - 1) Allows community treatment to restore competency. Proposed leg. 1983 - 1) Remove "irresistible impulse" criteria for NGRI. 2) Provide 1 trial for guilty and insanity determination. 3) Mandate court hearing prior to release of NGRI pt. from forensic facility.
HAWAII	X			ALI	defense	18	28	Legislation passed 1982 - 1) Moved burden/proof of insanity from pros. to def. Proposed leg. 1983 - 1) Set limits on length of stay of offenders committed to restore competency according to type of felony of misdemeanor charged. 2) Establish a forensic center. 3) Provide training and certification of insanity plea examiners.
IDAHO			X	ALI for MH treatment of convicted offenders	defense	6	N/A	Legislation passed in 1982 - 1) Abolished insanity defense, prohibits transfers from prison to state hospital except as voluntary patients, sets up standards (ALI) for disposition of convicted offenders who are mentally ill, abrogates mentally ill offender's rights to refuse treatment.
MONTANA			X	N/A	defense	N/A	N/A	Proposed legislation 1983 - 1) Totally eliminate any type of insanity plea. 2) Limit hospitalization of individuals found "unfit to proceed" to 90 days.
NEVADA	X			M'Naghten	defense	2	2	Proposed legislation 1983 - 1) Abolish the insanity defense and make it more difficult to discharge NGRIs (did not pass). 2) Provide consultation to courts and probation and parole personnel to increase the awareness of MIOs aftercare and medication needs. 3) Allow forensic hospital professionals to conduct evaluations for release.
NEW MEXICO	X	X		M'Naghten plus state vs. White	defense	1	N/A	Legislation passed in 1982 - I Added guilty but mentally ill to insanity defense law.
OREGON	X			ALI	defense	109	112	Legislation passed in 1982 - Reauthorization of psychiatric security review board system. 2) Eliminated "danger to self" as criteria of dangerousness. Proposed leg. 1983 - 1) Three bills to set up GBMI plea. One would abolish insanity defense. Other two would limit defense and severely restrict conditional release or discharge of NGI/GBMI.
UTAH	X	X		ALI	prosecution	?	N/A	Legislation passed in 1983 - 1) Revised insanity defense law to allow GBMI plea and conditional release of NGI/GBMI committed patients to community treatment.
WASHINGTON	X			M'Naghten	defense	173	N/A	Proposed legislation 1983 - 1) Add GBMI plea. 2) Establish more stringent requirements for any kind of release or leave of NGRI patients. All law enforcement agencies would have to be notified of release or leave.
WYOMING	X			ALI	prosecution	3	1	None

TABLE 10

COMMUNITY EVALUATION AND TREATMENT MENTALLY ILL OFFENDERS IN THIRTEEN WESTERN STATES
1981-1982

	Conditional Release of Forensic Facility Patients				Community Evaluation of Competency to Stand Trial				Community Treatment to Restore Competency			Community Evaluation of NGRI/GBMI				Community Treatment of NGRI/GBMI		
	Allowed by Statute	Who Author-ized	Who Super-vised	Who Prov. Treat.	Allowed by Statute	% Hosp.	% Comm.	Who in Comm.	Prov. in Comm.?	% Hosp.	% Comm.	Allowed by Statute	% Hosp.	% Comm.	Who in Comm.	Allowed by Statute	% Hosp.	% Comm.
ALASKA	no				yes	100%	0%		no	100%	0%							
ARIZONA	no				yes	few	most	cty hosp., jail, private prac.	yes	most	few	yes	few	most	private pract.	yes	most	few
CALIFORNIA	yes	court on recommen. of hosp.	county MH	county MH	yes	0	100%	private pract.	yes	97%	3%	yes	0%	100%	county MH	yes	66%	34%
COLORADO	yes	court	hosp. or MHC	MHC	yes	most	few	private pract. or MHC	yes (new law)	100%	0%	yes	major-ity	some	private pract. or MHC	no	65% (cond. release)	35%
HAWAII	yes	court	court & prb. & parole	Div. of MH	yes	90%	*	state and private	no	100%	0%	yes	40%	50%*	private pract.	yes	50%	50%
IDAHO	yes	court	court and MHC	MHC	yes	5%	95%	MHC or private	yes	95%	5%	N/A	N/A	N/A	N/A	yes	N/A	N/A
MONTANA	yes	court on recommen. FRB***	MHC	MHC	yes	most	few	private pract. or MHC	no	100%	0%	yes	most	few	private pract. or MHC	yes	NO DATA**	
NEVADA	no				yes	5%	95%	private pract.	yes	99%	1%	yes	5%	95%	private pract.	no	100%	0%
NEW MEXICO	no				yes	15%	30%	mobile eval. teams	yes	5%	30%	yes	25%	75%	mobile eval. teams	yes	N/A	N/A
OREGON	yes	PSRB	PSRB	MHC or Comm. Prog.	yes	some	most	private pract.	no	99%	1%	yes	10%	90%	private pract.	yes	75%	25%
UTAH	yes (since 1983)	Board of Pardons	Hosp., MHC or par/prb.	MHC or Hosp.	yes	few	most	private pract.	no	100%	0%	yes	few	most	private pract.	yes	99%	1%
WASHINGTON	yes	court	Com.Prg prb. & parole	MHC or Hosp.	yes	N/A	N/A	MHC or private	yes	unknown		no	100%	0%	MHC or private	yes	N/A	N/A
WYOMING	no				no	99%	1%		no	100%	0%	no	100%	0%		no	100%	0%

* 10 in correctional facility
** 5 NGRI patients were released to community in 1982
*** Forensic Review Board

Supervision of released offenders and, if necessary, recommendations for rehospitalization are the responsibility of the court and probation and parole office in Hawaii, the community mental health centers in California and Montana, the hospital or mental health center in Colorado, and is shared by mental health and probation and parole in Idaho, Utah, and Washington. In Oregon supervision is the responsibility of the PSRB. Recommended community treatment is generally provided by community mental health centers. In Colorado, Utah, and Washington the forensic facility may continue to provide outpatient treatment to released offenders or work closely with mental health centers providing treatment. Oregon has developed some specialized community programs for treatment of MIOs as well as providing funds to mental health centers for treatment of released offenders.

Most states do not have very good systems for keeping track of NGRIs who are placed in community treatment at the time of court disposition or are conditionally released to community treatment. California and Oregon have been able to track all NGRI commitments, whether in the hospital or community system, since about 1978. Supervision is maintained in those systems until the NGRI individual is discharged by the court. In Colorado the forensic hospital and in Hawaii the mental health corrections team maintain contact with most NGRIs, at least those committed initially to the forensic unit, until discharge. Other states were not able to provide data on the numbers of NGRI currently receiving treatment in community programs.

SUMMARY

The ten tables and the discussion presented above provide a picture of some of the similarities and differences in the systems which the thirteen western states have developed to handle the mentally ill offender in their states. The short summaries of each state's MIO system which follow add to that picture. This is a purely descriptive study and in no sense does it attempt to evaluate the effectiveness or efficiency of the different approaches, laws, programs, and procedures used by the states to handle MIO problems and populations.

The purpose of the study is to provide background information on the systems of care which have been and are being developed to respond to the needs and problems of mentally ill offenders. By design, this study concentrates on the forensic inpatient facility and respondents to the survey are, in most cases, associated with the forensic facility and their responses are given from the perspective of that facility. It is recognized that other possible respondents in the state--from corrections, community programs, and state agencies--might add information or respond differently to some questions. Respondents have been generous in providing estimates and opinions where hard data are lacking. We trust that the readers of this study also will be generous in forgiving errors which may have been made in responses to our questions or in the translation of answers by the compiler of the study.

As the availability and quality of information on state programs improves, it is hoped that future studies may make it possible to compare programs, MIO

populations, costs, staffing patterns, and other elements of the MIO system among the states more adequately and to identify the various contingencies--laws, policies, procedures, traditions, monetary incentives--which affect how a given state handles its MIO population.

SUMMARY DESCRIPTIONS OF STATE MENTALLY ILL OFFENDER SYSTEMS

ALASKA

Alaska is in the process of setting up a new forensic system. This is in response to legislation which became operational October 1, 1982. The legislation itself was in response to a class action suit requiring additional services and improvements in care for inmates of jails and correctional facilities in Alaska and community concern because an NGRI patient had been released from the hospital and subsequently killed four teenagers. The new laws include radically changing criteria for the NGRI law, making it much more difficult to plead NGRI and returning to the M'Naghten rather than the American Law Institute (ALI) criteria for determining mental illness. A guilty but mentally ill (GBMI) law was also passed (which retains the ALI criteria). Funding also was provided to establish a better evaluation and treatment system for care of mentally ill offenders.

The state is moving toward setting up a free-standing program administered by the state mental health agency. Two options under consideration for this program are (1) constructing a new building located close to the state hospital so that certain personnel and facilities may be shared or (2) establishing fifty to eighty beds at one of the correctional facilities with the mental health agency providing services. A new ten-bed forensic treatment and evaluation services unit, presently located at the Highland Mountain Correctional Center, provides only evaluation or examination services. Treatment services continue to be located at the Alaska Psychiatric Institute in Anchorage. That program has a psychiatric security unit which serves four or five transfers from jails, one incompetent to stand trial, and the remainder civil commitment or voluntary patients from the state hospital who need a secure setting. The other twenty-two-bed unit serves NGRI offenders. Six NGRI offenders are placed in treatment units in other parts of the hospital. Eventually the Highland unit will handle all evaluation and treatment for criminally committed patients, and API will handle only civil and voluntary security patients. The Highland unit is handling all court referrals for evaluation of offenders pleading NGRI, GBMI, or unfit to proceed.

Court-Ordered Evaluations

Alaska's criminal justice system includes state-administered jails, which are short-term holding facilities for offenders, and two correctional institutions located in rural areas, which provide longer-term incarceration. As Alaska does not have much capability to either evaluate or treat offenders in the community, almost all evaluations for fitness to proceed, NGRI, GBMI, or pre- and post-sentence disposition come to the forensic hospital. During the last year 250-300 evaluations were conducted at the Alaska Psychiatric Institute and it is estimated that 225 evaluations will be conducted by the new Highland unit during its first year of operation.

The director of the new forensic program has offered to provide consultation, evaluation services, and back-up to the newly authorized mental health staff in jails and correctional programs, which will include eight social

workers, eight psychologists, and five B.A.-level technicians to meet some of the needs of prisoners identified in the class action suit. The respondent said he hopes through this process to help screen inmates for the police and court in order to reduce the number sent to the forensic unit for evaluation. The new program will also try to shorten the period of evaluation--currently six to eight weeks--to two weeks in order to reduce the inpatient load.

Community Programs

The mental health centers are involved only rarely with mentally ill offenders in either the evaluation or follow-up phase. The respondent said he thinks it will be absolutely necessary for mental health centers or the courts to provide some screening of clients in order to make the forensic system work. At the present time, the courts do not know when the offender comes before the court whether his problems are related to drugs or alcohol, mental illness, retardation, or other causes. The state mental health staff development program is beginning to acquaint mental health center staff with the needs and problems of forensic clients through educational programs on their teleconferencing network.

Treatment Programs

Most offenders sent to forensic for evaluation are released after examination. If it appears that they will not be restored to competency within the year, they are discharged by the court and admitted to the hospital through civil commitment or voluntary means. Any clients unfit to proceed must be re-evaluated every ninety days and cannot be kept in the hospital as unfit to proceed for longer than one year. Treatment for these clients and others in the psychiatric security unit follows the pattern for acute care used by nonforensic units at the state hospital--milieu therapy, group and some individual therapy, medication, and recreation and occupational therapy. NGRI unit treatment uses a long-term care model with particular emphasis on modifying client expectations and assisting in setting up realistic in-hospital and post-hospital goals. There is no formal provision for conditional release of NGRIs to the community. Alaska has explored the possibility of setting up some type of system like Oregon's, in which an agreement between mental health and probation and parole might offer supervision and treatment to clients on conditional release. One problem is that the recent violent events in Alaska and the new legislation will make it very difficult to release an NGRI or GBMI back to the community. All GBMI whose mental illness improves will be sent back to jail for completion of their sentence.

Most Significant Current Problems

1. Increasing load on the forensic system. The GBMI plea may increase the forensic unit population as defense attorneys or police use that plea to hospitalize chronically mentally ill individuals who are bothersome but not dangerous. Although Alaska has had some misdemeanants hospitalized through the NGRI plea, the problem is not as severe as it is in Oregon and Hawaii. However, the civil commitment process is now so complex that courts are beginning to send misdemeanants to the forensic unit for examination and then offer to drop charges if the hospital will civilly commit them.

2. The commitment or "voluntary" admission of alcoholics to the state hospital (although this is generally not done through the criminal process). Apparently about 20 percent of all hospital admissions are alcohol-related.

3. Lack of space and facilities. It does appear the new legislation and funding will provide more adequate staff to handle MIOs. It is estimated that out of 1,400 prisoners in jails and correctional facilities forty or fifty are grossly mentally ill.

ARIZONA

Arizona has an unusual system for dividing responsibility for services to mentally ill offenders between the mental health agency and the Department of Corrections. In 1978, administration of the primary forensic unit at Arizona State Hospital--the Alhambra Unit--was transferred to the Department of Corrections. The Alhambra Unit with a bed capacity of 147 and average daily census of more than 200 is now used as an evaluation and reception center for the Arizona prison system. All prisoners are evaluated and classified at the reception center prior to being placed in one of the prisons or correctional facilities in Arizona. In addition, a forty-bed unit for evaluation and treatment of mentally ill prisoners is located at Alhambra. While the primary purpose of the forty-bed unit is to treat mentally ill offenders transferred from the prison system, the unit also provides evaluation to determine competence to stand trial and treatment to restore competency if indicated. The unit also provides presentence evaluation for convicted offenders if ordered by the court. The unit serves only males.

The state hospital also administers a forensic unit which is used primarily for civilly committed and voluntary patients from other units of the hospital who need a secure setting, but also conducts evaluations of competency to stand trial, treatment to restore competency, and treatment for women transferred from prisons.

Court-Ordered Evaluations

Although both forensic units may evaluate offenders for NGRI or competence to stand trial, most evaluations are done in the community. Counties outside the Phoenix and Tucson area may use one of the hospitals, with offenders requiring maximum security generally referred to the Alhambra Unit. Maricopa (Phoenix) and Pima (Tucson) counties have psychiatric units in their county jails which provide evaluation, observation, and treatment for offenders from those counties. NGRI are generally evaluated by private psychiatrists or psychologists in the county jail. If an offender is found incompetent to stand trial, charges are often dismissed, particularly if the patient is not dangerous. The offender may be civilly committed if inpatient hospitalization is indicated. Offenders undergoing treatment to restore competency receive protections similar to those of civilly committed patients in that a commitment may not exceed six months.

The Insanity Defense

The Arizona NGRI law does not provide for mandatory hospitalization of persons found not guilty by reason of insanity, even if they are dangerous. The court may seek civil commitment following acquittal. Legislation was passed this legislative session to shift the burden of proof of insanity from the prosecution to the defense. Other legislation has been submitted to require mandatory hospitalization if an offender is found NGRI. The legislation would also require authorization from the court before discharge. Currently there is no provision for conditional release of mentally ill offenders from

the forensic unit. It is probable that it may become even more difficult to release from the state hospital patients who may be dangerous because of a recent court decision holding psychiatrists liable for crimes committed by a formerly hospitalized patient.

Treatment Programs

Although criminal commitments to the forensic units are few, courts will often encourage "voluntary" admissions of individuals charged with crimes. An individual found guilty who is mentally ill may be given probation providing he or she seeks inpatient care. Charges against less serious offenders may be dropped in exchange for admission to an inpatient facility.

The treatment program at the forensic unit at the state hospital is similar to treatment programs in other state hospital units but emphasizes behavior management with various contingencies for acceptable behavior. Although there is no formal mechanism for conditional release, the forensic unit may recommend to the court that a patient be returned as a voluntary patient for treatment or to work out community placement and treatment through programs serving the chronically mentally ill.

Community Programs

The Department of Corrections (DOC) operates one outpatient program, in Phoenix. Although this program is primarily for parolees with physical health problems, it can also provide treatment and support for mentally ill parolees. The DOC also contracts for care with private psychiatrists and psychologists to provide outpatient treatment.

Prison Programs

The Department of Corrections' mental health program provides some mental health care in prison facilities. Full-time staff provide an inpatient program in the maximum security unit, Florence prison, the largest in the Arizona prison complex. Minimal medication and mental health services are provided in the other six correctional facilities. The DOC is currently planning a therapeutic community program in a separate building to provide inpatient care for mentally ill prisoners. The objective is to develop a seventy-two-bed primary inpatient treatment program for chemically dependent residents, an eighty-bed inpatient treatment program for mentally ill residents, and a twenty-four bed program for mentally retarded residents. This unit would serve all seven prisons and correctional facilities. The coordinator of the mental health program at the Florence prison, Gary Selvy, is recommending the new program because he believes that it is not possible to run a therapeutic treatment program in the midst of a large maximum security prison in spite of cooperation and support from the warden and other prison administrators.

MIO Legislation

In addition to the revisions to the NGRI statute, legislation has been proposed to expand the definition of danger to self and others; legislation to

provide for conditional release from the state hospitals; and legislation to allow transfer of prisoners to the state hospital forensic unit.

Most Significant Current Problems

1. Psychiatrists' liability ruling. The court decision holding psychiatrists liable if an ex-state hospital patient commits a crime after release is deterring releases from the state hospital. How to protect psychiatrists without unduly interfering with treatment decisions is a problem.

2. Relationship between the mental health and court systems. How to be responsive to the court's needs without being exploited is a continuing concern.

3. Pressure for tougher laws. The Steinberg case, in which Steinberg committed a particularly gruesome murder of his wife, was then found not guilty by reason of insanity, and "walked out the door," is resulting in community and legislative pressure to pass extremely restrictive NGRI legislation. Both mental health and corrections personnel are concerned about the need to balance the protection of the community and treatment needs of mentally ill offenders.

CALIFORNIA

Care for mentally ill offenders is shared by the state forensic hospitals and the county mental health programs. All examinations for competency and for NGRI are done at the county level. The county court appoints psychiatrists, usually from the private sector, to do these evaluations. Then the county mental health center does an evaluation in terms of disposition and recommends to the court whether the client should be placed in one of the state hospital forensic units or in the community. During 1982, 21 percent of all penal code clients evaluated were placed in community treatment. Eighteen patients, or 3 percent of all patients who were treated to restore competency, were treated in county programs.

Approximately 3 percent of NGRIs and 15 percent of "unfit to proceed" patients served by the forensic system last year were misdemeanants. The number of misdemeanants admitted to forensic facilities is increasing. One reason for this is that the state pays 100 percent of the cost for care of criminally committed patients whereas it pays 90 percent (10 percent by the county) for civilly committed patients.

Forensic Hospitals

Two of California's hospitals provide the major portion of forensic services and two others provide some services. Atascadero is the maximum security forensic hospital. Patton is the medium security hospital, currently providing 668 beds for forensic patients. This is being increased to 1,084 beds in 1982-83. Napa's patient population includes 270 penal code patients in its total patient population of 1,693. Napa is a minimum security hospital and penal code patients are mixed throughout the hospital with civilly committed patients according to their geographic region of residence.

The hospitals are divided into programs. At Atascadero there is a specialized program for incompetent to stand trial commitments, a family program, a sex offender program, assertiveness training program, and community planning program. Patton has similar specialized programs based on the needs and treatment goals of the patients.

The Atascadero program for persons found "unfit to proceed" includes a novel program in which role playing of typical court proceedings helps staff to assess patients' ability to understand the charges against them and cooperate with their attorneys, and it educates clients in court procedure. The average stay in this program is three to four months.

The Insanity Defense

California's NGRI statute uses the Proposition 8 standard of insanity under which the defendant must have been both incapable of knowing or understanding the nature and quality of his or her act and of distinguishing right from wrong at the time of the commission of the offense. The burden of proof is placed upon the defense to prove sanity by a preponderance of evidence once the issue of an offender's sanity is raised.

There were 228 admissions of individuals found NGRI to state hospitals in fiscal 1982. Nine hundred fifty-five NGRI patients are undergoing treatment at forensic hospitals. An additional 460 are receiving treatment or follow-up services in the community. The average length of stay for NGRIs in hospital treatment is 2½ years.

California, as with most other states, is facing proposed legislation to restrict NGRI pleas. One bill in the 1983 legislature is a form of guilty but mentally ill plea in which the patient who is guilty but mentally ill would be sent to the prison for thirty days and then transferred to the state hospital for treatment. The language of the bill indicates that patient would stay in the hospital until he/she "no longer has a mental illness." This would mean that most clients would stay at the hospital until their sentence was up and would have a huge fiscal and space impact on forensic services. Another bill would change the plea from NGRI to GBMI but would not change treatment discharge procedures.

Community Treatment

Patients may be conditionally released from the hospitals to a community treatment program. The state provides 100 percent state funding to special programs in eighteen counties which cover 70 percent of the state population specifically for development of programs and provision of treatment to conditionally released MIOs. Services are provided by the mental health centers or by other community programs through contract with the center. Services include outpatient, day treatment, halfway house, or whatever services seem appropriate. At the time a client is to be conditionally released, the county must be contacted and must agree to accept the client. A contract is written between the patient and the county outlining treatment goals and conditions. If the patient does not carry through with the agreed contract, the mental health center returns the client to inpatient care. Such contracts must be approved by the court, and the center must return to the court annually to receive authorization for continued treatment of a particular client. Most clients in this program are NGRI patients (292) and sex offenders (270). Eighteen "incompetent" clients were served in community programs during the past year. An additional 170 NGRIs are followed by state social services division. Therefore, a total of 460, or 34 percent of all NGRIs in treatment, are currently in community programs.

Prison Programs

All California prisons provide mental health evaluation, provision and monitoring of medication, and some levels of therapy. However, such programs are understaffed and, consequently, services are inadequate. In 1982, 108 prisoners received treatment at one of the mental health forensic hospitals.

A current initiative of the forensic program is to provide more consultation to state prison mental health programs, particularly in regard to discharges of mentally ill offenders.

Most Significant Problems

1. Uncertainty about programs. Because of California's fiscal crisis and a change in state administration, forensic personnel are concerned about what may happen to various programs recently initiated by the forensic program. Legislation passed in 1982 provides that sex offenders will no longer be treated at the state hospital but will go to prison. The mental health department and department of corrections have worked out an agreement to fill the 350-400 beds being vacated by sex offenders with prisoners in need of mental health treatment. Mental health consultation to prisons and increased cooperation between mental health agency and corrections personnel are other recent initiatives which may be jeopardized.

2. Transferring patients. Implementing legislation passed in 1982 which requires a plan to move all forensic patients from Patton Hospital (approximately 1,000) by June 1986 is a difficult task for forensic services. It is becoming increasingly difficult to place these patients at other state hospitals.

3. Insanity plea. Coping with any new legislation restricting the insanity plea would pose problems for the entire MIO system in California.

COLORADO

The forensic unit in Colorado is located at Colorado State Hospital. The other state hospital, Fort Logan Mental Health Center, does not handle penal code patients but does have a security unit for violent patients who are civilly committed or voluntary and need a secure treatment setting.

Forensic Hospital

The forensic program at Colorado State Hospital has a bed capacity of 350 and an average daily census of 357. The forensic program is divided into four units according to security level needed--maximum, medium, intermediate, and minimum security. Maximum and medium security patients are located in a locked facility with a security fence. Intermediate and minimum security patients are located in other wards on the hospital grounds. The average daily attendance of maximum security patients is 133, medium security 120, intermediate 42, and minimum 62. The treatment program is set up to encourage patient movement to lesser security units, to help them become more responsible for their behavior, and to give then increasing privileges in the less secure units. Although subunits focus on different aspects of treatment or behavior, the same type of treatment techniques are used, including individual and group therapy and recreational, occupational, and milieu therapy. Colorado is experiencing an increase in average daily census in their forensic program. This seems due in part to an increase in numbers of offenders referred for evaluation of competency to stand trial and also due to the relatively long length of stay of offenders found not guilty by reason of insanity. Colorado has a large number of admissions--148 in fiscal 1982--of individuals with criminal charges pending but who are being evaluated for civil commitment. These individuals are held for seventy-two hours, evaluated, and returned to the court. If committed, they would most often be placed on other treatment units at the state hospital.

Incompetency to Stand Trial

Most court-ordered evaluations for competency to stand trial are conducted by the forensic unit in Colorado. However, the statute does allow for evaluation in the community. The increase in admissions for evaluation of competency seems to be associated with a slight decrease in admissions of individuals to be evaluated for NGRI. This may indicate that defense attorneys are finding it more difficult to have an NGRI plea considered by the courts. All offenders committed for treatment to restore competency are treated at the forensic unit. The 1981 law provides for community treatment to restore competency if no violent behavior was involved; but the law is new and the community treatment provisions have not been used. The requirement of nonviolent behavior may also be affecting usage of this new law.

Insanity Defense

The Colorado insanity defense law requires the prosecution to prove an offender sane "beyond a reasonable doubt" once the insanity plea has been raised by the defense. The criteria for a finding of insanity has been a

modified M'Naghten criteria which included "irresistible impulse." The "irresistible impulse" criterion was deleted in the 1983 revision of the law. The revision of the law also includes a provision mandating a court hearing prior to an offender's release from the forensic hospital and changing the burden of proof to the defendant, by a preponderance of evidence to prove that he "has no abnormal mental condition which would be likely to cause him to be dangerous either to himself or others or to the community in the reasonably foreseeable future, and is capable of distinguishing right from wrong and has substantial capacity to conform his conduct to the requirements of law." Currently, the law provides for a court hearing when the district attorney contests the hospital's recommendation for release or when the hospital is not recommending release and the burden of proof by a preponderance of evidence is on whoever contests the hospital report.

The 1983 legislature, also, considered but did not pass legislation to change from the bifurcated trial, in which separate trials are conducted for findings of guilt and for insanity. The concept of guilty but mentally ill has not received much support in the Colorado legislature.

Prison Programs

A small mental health staff at the prison provides evaluation services and provision and monitoring of medication. Most inmates requiring intensive mental health treatment are transferred to the state hospital forensic program. The prison also has the beginnings of a sex offender program. Statistics are not available on numbers of inmates served by the prison program.

Community Programs

The insanity statute does provide for conditional release of offenders found not guilty by reason of insanity. Approximately 125 NGRIs are currently being treated in the community, primarily at community mental health centers. The forensic program provides consultation and backup to the mental health centers regarding conditionally released patients. There is considerable variation among the mental health centers as to the quantity and quality of services provided to offenders. Some centers work closely with police and jail personnel, provide consultation and staff training, and provide regular evaluation and treatment services for individuals who are arrested or jailed. Other centers provide virtually no services to the offender population. The state mental health division is encouraging centers to provide more services to this population, particularly follow-up of offenders released from the forensic units at the state hospital.

Most Significant Current Problems

Significant problems identified include:

1. Rigid release criteria--not just "no longer mentally ill" but also "not dangerous."

2. Inadequate funding.

3. Cumbersome statutes for incompetent to proceed to trial cases.

HAWAII

The Hawaii system probably provides more assistance from mental health to the courts and corrections system than any other of the western states. In addition to the forensic hospital, Hawaii has an independent forensic team which is part of the mental health division in the Department of Health. The team has eighteen staff including five psychiatrists, eight psychologist positions filled by nine or ten different psychologists, and one full-time social worker. Others are secretarial and support staff. The team not only provides direct assistance to the courts and corrections but also provides mental health professional services in the prison. Two psychiatrists and one full-time psychologist are based at the prison. In addition, one psychologist is placed full-time on the island of Hawaii. Forensic team services on the two islands of Maui and Kauai are provided by mental health center staff. A more detailed description of the Hawaii program is included elsewhere in this publication.

Court Evaluations

Each day the forensic team goes to the state district courts to evaluate offenders who are referred by the court "intake service center" social workers. Individuals found to be mentally ill, unfit to proceed, and not candidates for outpatient evaluation are referred to the forensic hospital for examination.

Those whose conditions are such that they can be evaluated as outpatients are referred to the appropriate mental health center. Individuals are evaluated and within thirty days a report is made to the court as to their fitness to proceed, responsibility at the time of the offense, and recommended disposition. These individuals are for the most part misdemeanants, who tend to be chronically mentally ill and have long histories of contact with state mental hospitals. They are usually stabilized rather quickly by being placed on medication and most often can be released after examination and do not need to be committed for treatment.

Hawaii has noted a rapid increase in examinations of individuals who are misdemeanants. This is apparently partly due to the strictness of the civil commitment laws in Hawaii and partly due to police and community concern about vagrants and nondangerous CMIs whose behavior is unacceptable to the community. Although the number of admissions of misdemeanants has risen sharply, by and large they do not generally require hospital treatment past the examination period.

Treatment for Incompetence to Stand Trial

Comparatively few individuals are committed to the hospital for treatment to render them competent to stand trial. Fifteen were so admitted in calendar 1982. This may be partly due to a statutory provision allowing extension of the evaluation period and partly to the number of misdemeanants who are stabilized on medication during the evaluation period.

Currently the Hawaii law does not provide any limit on the length of time a person committed to the hospital as incompetent to stand trial may be hospitalized. There is proposed legislation to put some limits on this based on the type of felony or misdemeanor charged.

Insanity Defense

In regard to NGRI, the ALI rule is used in Hawaii. The law was changed in 1982 to place the burden of proof on the defendant for proving "insanity." An individual found NGRI is hospitalized only if he is a danger to the community. NGRI patients are encouraged to contact the public defender regarding initiating discharge or conditional release petitions. Although comparatively few NGRI are admitted to the hospital--eighteen in 1982--their length of stay is quite long. Thirty-eight percent of all current patients on the forensic unit are NGRI. An additional twenty-two NGRI are housed in other units in the hospital. Approximately one-half still in the mental health system are in community treatment.

In Hawaii as in other states, there seems to be more pressure to change the NGRI statute this year although the legislative leadership is suggesting revising the entire penal code rather than making changes piecemeal.

Corrections Programs

Because mental health treatment of state prison inmates is provided at the prison and because prisoners generally resist transfer to the state hospital (because of the stigma), few mentally ill offenders are transferred from the prison to the state hospital for treatment. The mental health corrections team provides treatment services in the prison. The team also evaluates all prisoners prior to discharge, whether or not the prisoner is mentally ill. The team estimates that 20 to 25 percent of prison inmates are in need of some type of mental health intervention--many of them for alcohol and drug abuse.

Similar services are provided at the Hawaii Youth Correctional Facility for incarcerated youth.

Court Programs

In addition to the examinations and services provided by the forensic center at the Hawaii State Hospital, various members of the courts and corrections team provide additional services to every court in Hawaii dealing with offenders. These additional services include presentence evaluations, parole revocation evaluations, outpatient sanity commissions, and case consultation. The team also services the Family Court and provides mental health input on waiver cases, divorce cases, custody cases, and other related family and delinquency issues.

Most Significant Current Problems

1. Increasing admissions. Hawaii is faced with increasing admissions and readmissions to the forensic unit, particularly of misdemeanants.

2. Community treatment. There is a need to provide better supervision and treatment in the community in order to reduce recidivism and help offenders readjust to the community.

The corrections mental health team and the state manpower development program have recently organized a task force which is exploring ways to strengthen community treatment and possibly to establish a mental health probation officer who would be responsible for supervising conditionally released prisoners and reporting to the court any violations of conditions for release. Each of the mental health centers has identified a liaison person to work with the corrections team to set up community supervision and treatment programs. A bill has been introduced in the state legislature regarding this new system.

Insanity Defense

Idaho eliminated the plea of not guilty by reason of insanity in 1982. Prior to that time, the evaluations of offenders on the question of fitness to proceed as well as those not guilty by reason of insanity were consolidated into one evaluation. Since the change in the law, evaluations are still conducted for fitness to proceed. Most evaluations under both the old system and the new system are conducted in the community by community mental health center licensed psychologists and psychiatrists. Between nine and twelve evaluations for insanity defense and fitness to proceed were conducted annually at the forensic unit at the state hospital prior to the change in law. During fiscal 1983 the number of evaluations of fitness to proceed has been reduced to three or four.

Although the insanity defense is technically no longer available, the law still provides for mental illness to be taken into account in assessing the offender's intent in committing the crime. An offender may be found not guilty because he was not able, due to mental illness, to have the particular state of mind necessary to be found guilty. An unexpected result of the new law may be that an offender whose mental illness keeps him from having the necessary intent could be found not guilty and even though dangerous, could not be committed to the state hospital except through civil proceedings.

The new law makes it possible for the court to authorize treatment for mentally ill felons who would otherwise be placed at the prison. That section of the law also makes it possible to require treatment and abrogates the client's right to refuse treatment. The ALI criteria are used by the court to determine whether or not a convicted felon may need mental health treatment.

Competency to Stand Trial

Approximately 95 percent of court-ordered evaluations for competency are conducted in the community by licensed psychologists and psychiatrists. Offenders found incompetent may be committed to the Department of Health and Welfare, which places them in appropriate community or hospital treatment programs.

Forensic Hospital

The mental health division administers the medium security forensic unit at the state hospital. Maximum security is located at the prison under the administration of the Department of Corrections. New admissions to medium security have declined somewhat with the passage of the new law; however, a number of offenders committed as NGRI under the old law remain at the medium security unit. Also, NGRI commitments had been placed in other units at the state hospital. About 40 percent of NGRI commitments under the old law were misdemeanants; 60 percent were felons.

The twenty-bed medium security forensic unit at the state hospital provides evaluation of competency to stand trial and presentence evaluation of convicted offenders. Types of clients admitted for treatment include commitments for restoration of competency, transfers of convicted misdemeanants or felons from jails or prison, and civil commitments or voluntary patients from the general state hospital population in need of a medium security setting. Idaho law does not provide mental health treatment for sexual offenders.

Prison Programs

All incoming inmates at the prison are assessed at the diagnostic center and mental health treatment may be recommended at that time. The inmate may be placed in either the inpatient or outpatient program at the prison or may be transferred to the state hospital forensic program on a voluntary basis.

The thirteen-bed inpatient maximum security unit at the prison also provides presentence evaluations and treatment if indicated for offenders who need a maximum security setting. Treatment is provided by private mental health practitioners through contract with the Department of Corrections.

Community Treatment

Persons sent to the forensic hospital under the old law as NGRI or those sent as unfit to proceed may be conditionally released to the community. The procedure is to develop a specific plan for the MIO, go to the court for approval of that plan, and then transfer the individual to the mental health center for ongoing treatment.

Offenders, particularly misdemeanants, may also be found guilty by the court and placed on probation with mental health treatment as a condition of probation.

Most Significant Current Problems

Interpretation of the law. The most troublesome problem faced by the state mental health agency in Idaho at the present time is working with the courts and prosecuting and defense attorneys regarding interpretation of the new law. The subtleties of the law are being interpreted differently in different courts. Both the mental health and corrections agencies are trying to assess the potential impact of the law on admissions to the forensic units and procedures which need to be developed in response to changes in the law.

Insanity Defense

Montana is one of two states in the region which has technically abolished the insanity defense. Prior to 1979, Montana did not have separate legislation regarding a defendant's competency to stand trial. Legislation which replaced the insanity defense provides for examination to determine a defendant's competency to stand trial and also makes it possible for a defendant to plead not guilty "for the reason that due to a mental disease or defect he could not have a particular state of mind that is an essential element of the offense charged." Although the number of defendants pleading not guilty under this new statute has decreased--three in 1981 and none in 1982--the number of competency evaluations and commitments to restore competency have increased. Apparently defendants who might formerly have been examined and committed as NGRI are now being examined and treated as incompetent to stand trial.

Forensic Hospital

Since October 1981 the state has been required to pay for penal code evaluations and treatment if indicated. This has resulted in a substantial increase in numbers of admissions and daily census at the forensic unit.

Treatment is provided to an average of sixty-six patients in two maximum security units and one male and one female medium security unit. Treatment includes individual and group therapy, current events groups, basic living skills group, resident employment program, recreational therapy, education programs, and chemotherapy.

Comparatively few misdemeanants are committed through criminal court proceedings to the forensic unit. Misdemeanants are generally given the option to accept "voluntary" hospitalization if charges are dropped and most often are admitted to the alcohol and drug abuse ward at the hospital.

Competency to Stand Trial

Although defendants may be evaluated in the community or in the state hospital, most evaluations are conducted in the state hospital. This is true because the state pays for evaluations at the hospital and because evaluations must be conducted by psychiatrists and there are few psychiatrists in Montana. Region III, including Billings, which has more psychiatrists than other regions in the state, refers fewer defendants to the hospital than other regions.

Defendants found incompetent to stand trial are committed to the state hospital until the offender is no longer mentally ill. Legislation is being proposed to limit their length of stay to ninety days.

Community Treatment

Offenders found not guilty by reason of mental disease or defect under the old or new statute may be conditionally released to community treatment. Five were released in 1982. Conditional release is limited by the fact that group homes are few in Montana and they are usually unwilling to accept criminal defendants. The forensic unit has a gradual re-entry program and is attempting to find community placements and appropriate supervision through community mental health centers for forensic discharges.

Prison Programs

A staff of six social workers, two psychologists, and one day a week consultation from a psychiatrist or psychologist provide minimal mental health services at the prison. Services include intake information screening for transfer to the state hospital, minimum psychiatric treatment, and monitoring of medication. Approximately 350 prisoners are served annually.

Most Significant Current Problems

1. No time restrictions for persons committed as unfit to proceed. This raises constitutional questions.

2. Treatment vs. security issues. The fact that persons found GBMI are sentenced to the mental hospital makes establishing a therapeutic program difficult.

3. The lack of community treatment programs and aftercare for persons discharged from the forensic unit.

4. Ambiguous laws. Although NGRI was supposed to be abolished by 1979 legislation, laws are ambiguous. Legislation was introduced in 1983 to eliminate any type of insanity plea.

Forensic Hospital

In the Nevada system, evaluations of offenders for competency to stand trial and insanity pleas are conducted by private sector psychiatrists who are paid by the courts. Treatment is provided at Lake's Crossing Center for the mentally disordered offender. Lake's Crossing is a free-standing forensic facility established in 1976 with a bed capacity of thirty-two.

The purpose of the facility is primarily to restore offenders to competency to stand trial. However, thirteen NGRI offenders have received treatment there since 1976; and two were in the facility during 1982. Thirty-eight civilly committed or voluntary patients who need a secure setting were admitted from either the state hospital or community programs and six persons were transferred from the prison in fiscal 1982.

The census at Lake's Crossing has been going up steadily--115 were admitted in 1982. Seventy to 80 percent of admissions are felons. The misdemeanant group has remained fairly steady although a class action suit at the Las Vegas County Jail has resulted in a slight reduction in commitment of misdemeanants from Las Vegas County. There may be a relationship between the increase in admissions and the state's population increase and, to some extent, judges' and attorneys' increasing awareness of the incompetency statute. In order to control the population, Lake's Crossing reduced the length of stay from seventy-nine days to fifty-nine days during 1982.

Incompetency to Stand Trial

In Nevada most evaluations for competency to stand trial are done in the community by a psychiatrist who sees the offender at the jail. The examination is sent to the court and the court may then order the offender to Lake's Crossing for treatment. When staff at Lake's Crossing feel the patient has been restored to competency, a panel of three private psychiatrists examines the offender at the forensic facility and makes recommendations to the court. The offender is then returned to the court for disposition. If it appears probable that competency will not be restored, the evaluation team so reports to the judge, charges are dropped, and the facility pursues civil commitment for the offender. When civilly committed, the offender is placed at the state hospital and thereafter comes under its jurisdiction. The limit for treatment of incompetents is ten years, but the offender's status is reviewed every six months.

Insanity Defense

Offenders pleading NGRI go through much the same procedure, except that the criteria for commitment to Lake's Crossing are somewhat different, involving dangerousness. Also, offenders stay at Lake's Crossing even if they are civilly committed. Lake's Crossing staff, including psychiatrists, psychologists, social workers, or nurses, examine the client and submit reports to the

court regarding placement for treatment. Eleven of the thirteen NGRIs committed since 1976 have been moved to the state hospital or community treatment or have been discharged; the other two clients remain at Lake's Crossing. NGRIs may be moved to the community or other treatment if the judge, the district attorney, and the public defender concur with Lake's Crossing's recommendation. Offenders undergoing treatment for incompetency generally are not moved to another setting unless they are restored to competency or civilly committed.

Legislation was proposed to try to abolish the insanity defense and to make it more difficult to discharge NGRIs. However, the fact that very few offenders successfully plead NGRI caused this legislation to be dropped.

Community Treatment

Treatment provided at the Lake's Crossing Center is described in the paper "Treatment in Forensic Hospitals and Prisons" in Section I. Aftercare or community treatment is limited and is not a formal part of the forensic program. An offender may be conditionally released to the community with provisions for treatment at a mental health center or by a private practice professional, but this does not occur frequently. Pending legislation would provide stronger links between community programs and personnel and the forensic program.

Prison Program

The prison has a psychiatric program with ninety inpatient beds. Staff is limited to one consulting psychiatrist, two psychologists, and some registered nurses. Inmates are hired as mental health technicians in the program. The program is for the purpose of evaluating all prisoners prior to discharge as well as treating those who are mentally ill. Most patients who are transferred to Lake's Crossing for treatment are women prisoners as there is no prison program serving women. Lake's Crossing has a liaison person who consults with staff at the prison every two weeks.

Most Significant Current Problems

1. Competency evaluations. A major problem faced by the Nevada facility is a statutory provision which requires that three private psychiatrists conduct court-ordered evaluations of incompetency to stand trial and evaluations regarding restoration of competency. The present system is expensive and delays discharges from the Lake's Crossing Center.

2. Aftercare coordination. There is a need for better coordination with the courts and probation and parole personnel to improve community aftercare services for mentally ill offenders. The Mental Health Division is supporting legislation which would allow setting up programs to work with the courts to make them more aware of the need for aftercare and medication maintenance and to provide supervision or consultation with parole and probation personnel in supervising discharged offenders.

NEW MEXICO

In 1976 the forensic system of the New Mexico Health and Environment Department began to offer community-based evaluation services to the state criminal justice system, including the district courts, district attorneys, public defenders, and adult probation and parole. Mobile evaluation teams consisting of Ph.D. psychologists, master's level social workers, psychometrists, and evaluators were established by the state mental health agency to serve the thirteen judicial districts. The six teams currently conduct most examinations for competency to stand trial, evaluations for insanity or guilty but mentally ill pleas, and presentence evaluations requested by the courts.

The Forensic Hospital

Forensic services are provided by a separate forensic hospital in Las Vegas administered by the state mental health agency. The forensic hospital contracts with the New Mexico state hospital also located in Las Vegas for some supportive and general diagnostic services. The hospital is composed of one maximum security and three medium security units, including one which provided services to thirty-eight clients suffering traumas from the February 1980 penitentiary riot. The latter program was phased out in February 1983.

As the routine evaluation load decreased, the forensic hospital has been able to expand its services into other areas of higher need. The hospital has begun to do more treatment of special populations, specifically of institutional transfers from the penitentiary and of probationers referred from the courts. At any one time approximately ten of the ninety hospital beds are taken up by evaluation cases, thirty-five to forty by institutional transfers from the penitentiary, twenty for probationers, and another twenty allotted for "treat until competent" cases.

Competency to Stand Trial

Approximately two-thirds of the offenders examined to determine competency to stand trial are evaluated in the community, one-third in the forensic hospital. Those found incompetent to stand trial and sent to the hospital for treatment are treated and evaluated to see if they can become competent. Many of these people are sent to the hospital in an actively psychotic state due to schizophrenia or a bipolar disorder. They can usually be medicated and quickly regain competency. If treatment is effective within a two-year period, the mentally ill offender is returned for trial or plea and then follows the same procedure as a defendant found competent. Defendants frequently plead to lesser offenses in exchange for continued forensic treatment with credit for time served. If treatment is not effective within a two-year period, in accordance with the Jackson v. Indiana decision there must be a civil commitment to the New Mexico State Hospital.

Insanity Defense

In New Mexico, when a crime is committed and there is a question of the defendant's sanity, a pretrial evaluation is ordered to determine the placement of the defendant. This is done by statewide forensic evaluation teams, court clinic, forensic hospital, or by private psychologists or psychiatrists. If the judge or jury finds the defendant competent, a trial is held with the defendant pleading one of three ways: (1) not guilty by reason of insanity; (2) guilty; (3) guilty but mentally ill (new statute).

Although the NGRI plea frequently is used, it usually is not successful. A finding of NGRI results in a civil commitment on a judge's motion to the New Mexico State Hospital. A guilty plea could result in probation. This may include inpatient treatment at the forensic hospital or specific program or community-based treatment, or commitment to the Department of Corrections. A guilty but mentally ill plea could result in a commitment to the forensic hospital for less than one year or a commitment to the Department of Corrections. A commitment to the Department of Corrections could include a sixty-day presentence evaluation, full commitment, transfer by existing procedure to the forensic hospital, or parole to the forensic hospital by the Parole Board.

Community Treatment

New Mexico law does not provide for conditional release of penal code commitments to community treatment. However, the law does provide that persons found not guilty by reason of insanity or guilty but mentally ill may be committed to a community facility rather than the forensic hospital. Agreements also have been worked out with the courts which allow forensic evaluation teams and first offender programs as well as probation and parole to refer clients to local community mental health centers for treatment.

Prison Programs

Approximately 148 inmates of the prison are served by a separate psychological unit at the prison staffed by ten psychologists and four secretaries. The prison program provides for evaluation, provision and monitoring of medication, group and individual therapy, and rehabilitative therapies. Prisoners requiring more intensive treatment may be, with their consent, transferred to the forensic hospital.

Most Significant Current Problems

1. Community programs. Progressive movement of clients to appropriate community settings and development of halfway houses and community programs for offenders are identified as needs of the MIO system in New Mexico.

2. Tight budgetary constraints.

3. Reduced capacity. The plans to open a female unit will reduce the capacity for handling male offenders by ten beds.

4. Public concern. As a result of the Hinckley decision, there is public outrage resulting in a promise from the governor that "criminals will be prosecuted." Although a GBMI law has been passed by the legislature, its effect on calming community concerns about mentally ill offenders is not yet known.

OREGON

Oregon has a comprehensive, fairly sophisticated system for care of mentally ill offenders that places almost all treatment under the administration of the Mental Health Division with funding shared by the Mental Health Division and Department of Corrections. Elements in the system include six thirty-bed units in the forensic unit of the hospital; a 120-bed unit at the state hospital which is run by the Division of Mental Health but funded by the Department of Corrections exclusively for prison inmates; and specific funding support to mental health centers to provide aftercare. The system for dealing with offenders found not guilty by reason of insanity includes a continuum of services under supervision of the Psychiatric Security Review Board which is responsible for placement and supervision of offenders in the most appropriate treatment setting. This system is described in papers by Joseph Bloom and Jeff Rogers. Statistics provided in this survey relate only to the six thirty-bed units of the forensic unit, not those funded by Department of Corrections.

The forensic population at Oregon State Hospital has been increasing at a rate of about 6 percent per year for the last several years. At the same time, other units of the state hospital are decreasing approximately 10-12 percent per year.

Court Evaluations

Oregon law permits evaluation in the community for fitness to proceed and for NGRI. It is estimated that up to 90 percent of the NGRI offenders and the great majority of the unfit to proceed offenders are evaluated in the community. This is partly because the state hospital charges the court $460 evaluation cost plus the daily hospital charges, whereas evaluations in the community can be purchased for about $150. Virtually all offenders committed for treatment to restore competency are treated in the hospital rather than the community.

Insanity Defense

The NGRI law requires the defendant to prove insanity. Oregon is experiencing an increase in the number of misdemeanants being hospitalized as NGRI and the assumption is that this is due largely to the stringent requirements of the civil commitment law. In 1981 the legislature passed a law eliminating "danger to self" as part of the definition in the NGRI law and this has had some effect in reducing the number of misdemeanants found NGRI.

Several major changes in the law affecting mentally ill offenders in Oregon were made in 1978. One of these was setting up the psychiatric review board; another was making money available to mental health centers to set up community programs; another was establishing the 120-bed unit at the state hospital for prison inmates. Legislation in 1981 reauthorized the psychiatric review board and deleted "danger to self" as a criterion for mental illness.

Three bills were submitted to the Oregon legislature in 1983 dealing with the NGRI defense. All three would establish a guilty but mentally ill plea.

One would abolish the NGRI defense and the other two would limit the defense in such a way that very few offenders would qualify. These laws would also prohibit the Psychiatric Security Review Board from conditionally releasing patients (to community care, for instance) who are first-degree felons. It would not affect others. It is estimated that the effect on the hospital of passage of any of these three laws would increase the average daily attendance at the forensic hospital by thirty new patients per year and would require setting up one new ward per year.

Prison Programs

The prison also has specific programs for offenders including a forty-five-bed inpatient unit in the prison for prisoners requiring that level of care; a program which pays for outpatient therapy provided by outpatient therapists from mental health centers or the private sector who provide group and individual therapy at the prison; and the "corrections treatment program" at the state hospital.

The corrections treatment program includes four units of thirty beds each. Inmates must volunteer for this program and must be within twelve to eighteen months of parole. Units are set up specifically for treatment of drug and alcohol abuse problems; sex offenders; mentally ill prisoners; and inmates who are developmentally disabled, chronically mentally ill, or socially deprived who have not learned basic community living skills and tend to get in trouble with the law because they are not able to manage their daily lives.

Community Programs

Oregon law provides for conditional release of NGRI patients to the community. Release decisions are made by the Psychiatric Services Review Board which provides for supervision and community treatment and prompt return to the hospital if conditional release provisions are violated. Approximately 25 percent of all NGRI patients receiving treatment are served by community programs.

Oregon has provided funds to mental health centers and other community programs to establish appropriate community treatment and support for MIOs.

Most Significant Current Problems

1. Lack of resources. Staff often have to carry outpatient case loads of offenders on their own time in order to ensure that offenders have the kind of treatment needed to help them become eligible to be released.

2. Legal difficulties. Activities of legal aid and prisoner services result in staff having to spend valuable professional staff resources on re-examination of offenders, on defending themselves and explaining their actions in a legal setting, and in having to set up a number of administrative rules which would not be necessary were it not for legal challenges.

3. Inability to release dangerous offenders who have been found not guilty by reason of insanity but later found not to be mentally ill. Because of their

dangerousness these patients cannot be released from the hospital, but there is nothing the hospital can do for them because they are not mentally ill. There are approximately six of these patients who will probably be at the hospital for the rest of their lives.

4. Lack of data on number of insanity pleas per year. Data about NGRI pleas--the frequency of their use and their success--is not centralized in Oregon but scattered in the files of each court in the state. A possible solution to this problem would be to send copies of these court actions to a central point, such as the supreme court, although this would require legislative authorization. Oregon respondents would like information on such systems from states that have them.

UTAH

The 1983 session of the Utah General Assembly passed legislation revising its insanity defense law. This legislation is the result of a year-long study of the insanity defense. Major changes in the law include addition of a guilty and mentally ill plea and restriction of the insanity defense to a finding that the defendant lacked the mental state required as an element of the offense charged. Mental illness shall not otherwise constitute a defense. The statute specifically states that a person who is under the influence of voluntarily consumed or injected alcohol, controlled substances, or volatile substances at the time of the alleged offense shall not thereby be deemed to be excused from criminal responsibility. The new law also allows for conditional release of NGRI or GBMI patients. With the concurrence of the court, offenders found not guilty by reason of insanity or guilty and mentally ill may be given probation or placed on parole. Continued treatment in a community mental health facility may be made a condition of probation or parole.

Forensic Hospital

The forensic unit at the state hospital in Utah has a bed capacity of eighty-eight and an average daily census of ninety-one. The program is divided into three units: a forensic security unit, a forensic sexual offender unit, and a general forensic unit. The forensic program provides for a limited number of evaluations, primarily of convicted offenders referred for presentence evaluation and transfers from prison for evaluation. Treatment modalities are similar to those at other units of the state hospital.

Incompetency to Stand Trial

Very few offenders are referred to the forensic hospital for evaluation of competency to stand trial or for treatment to restore competency. Only two individuals were admitted for evaluation of competency and three admitted for treatment to restore competency in fiscal 1982. If offenders are found not competent to stand trial and it appears that they will not become competent within six to nine months, the charges may be dismissed (unless they are of an extremely serious or violent nature) and the individual civilly committed to the Utah State Hospital. There is no statutory limit in Utah on the length of time an individual may be held while undergoing treatment to restore competency. Counties are charged $150 a day for competency and insanity examinations, which may account for the relatively low number of competency and insanity exams conducted by the forensic facility.

Insanity Defense

The changes in the insanity defense law are too new to assess what impact the modifications may have on the forensic units or the mentally ill offender system in Utah. Prior to passage of the new law, only two individuals were admitted to the forensic facility for an insanity examination and only two were committed to the hospital as NGRIs in fiscal 1982.

Prison Programs

A small mental health program at the prison provides evaluation, medication, and some group therapy within the prison setting. Approximately twenty to twenty-five inmates are served per year. Prison inmates may be transferred to the state hospital for treatment providing that they meet the criteria for civil commitment. A hearing is held before a federal judge prior to transfer. An inmate has to apply for the program and is selected on the basis of motivation, nature of offense, jeopardy in the general prison population, and availability of slots. Prison inmates most often transferred to the state hospital for treatment are sex offenders, drug and alcohol abusers, and youthful or limited mental capacity offenders.

Community Programs

Most examinations for competency and NGRI are conducted by court-appointed examiners from the private mental health sector. Community treatment varies according to the interest and expertise of the various community mental health centers and drug and alcohol programs. There is no structured process for moving mentally ill offenders from hospital treatment to less restrictive treatment in the community, and this is identified as one of the most troublesome problems in dealing with mentally ill offenders in Utah.

Most Significant Problems

The most significant problems identified by the Utah informant are:

1. Process for getting mentally ill offenders gack into the community.

2. Interpretation of the legal requirement that an individual must be "restored to sanity" prior to discharge. Questions are, can sanity be restored while the individual is on psychotropic drugs? and what are the differences between "restored" sanity and remaining a danger to self or others?

Forensic Hospital Units

Washington has forensic units at both Eastern State Hospital and Western State Hospital. The Eastern State Hospital forensic program includes four units: one for competency determination including evaluation and treatment; two units for treatment of NGRI for two intellectual levels of patients; and one unit for treatment of sexual offenders committed by statute. Western State Hospital has a sex offender program and a mentally ill offender program, which includes an evaluation unit, inpatient treatment, and a community program.

The average daily attendance (ADA) in the mentally ill offender program and the sex offender program fluctuates, at times being higher for the sex offender program; however, the bed capacity of the mentally ill offender program is 208 and that of the sex offender program is 192. Approximately 35 percent of the bed capacity and ADA at Eastern State Hospital are sex offenders. The forensic facilities in the Washington state hospitals do not serve voluntary or civilly committed patients in need of a secure setting. The proportion of forensic admissions who have been found not guilty by reason of insanity is higher in Washington than any other western state except Oregon.

Both Eastern State Hospital and Western State Hospital provide a continuum of services, including community services for both sex offenders and mentally ill offenders. The sex offender program includes admission evaluation, self-help guided group therapy, work release, and outpatient treatment. The mentally ill offender program provides admission evaluation, inpatient treatment, community program, and follow-up for conditionally released patients, which includes medications, group therapy, a modified therapeutic community program, and a step program, including behavior modification. Treatment programs at Eastern State Hospital include competency groups, medications, group therapy, self-help groups, step programs, and behavior modification.

Incompetent to Stand Trial

Evaluations for competency to stand trial may be conducted at either the state hospital forensic unit or in the community by two qualified experts or professional persons appointed by the court or designated by the Department of Social and Health Services. Respondents were not able to estimate the proportion of competency examinations conducted in the community versus the hospital. Individuals found incompetent to stand trial are committed to the custody of the secretary of the Department of Social and Health Services, who places the defendant in an appropriate facility for evaluation and treatment. Although this placement may be in either the community or the hospital, treatment for restoration of competency generally occurs in the hospital. Initial treatment for restoration of competency is for a period of ninety days. The maximum period of time an individual may be committed as incompetent to stand trial is one year. If the individual remains incompetent at the end of that time, charges are dismissed without prejudice and either civil commitment proceedings are instituted or the court may order release of the defendant.

The Insanity Defense

The insanity defense law places the burden on defendants to prove by a preponderance of the evidence that they meet the criteria for insanity. Criteria follow the M'Naghten rule. An individual found not guilty by reason of insanity who is not a substantial danger to other persons or does not present a substantial likelihood of committing felonious acts jeopardizing public safety or security is discharged by the court. Felons who are found to be a substantial danger to other persons or present a substantial likelihood of committing felonious acts jeopardizing public safety or security are committed to the hospital or other appropriate treatment facility. Misdemeanants are released or retained in custody for a reasonable time to allow the county-designated mental health professional to evaluate the individual and to proceed with civil commitment, if appropriate. Felons may be retained in the hospital or treatment setting until they are no longer a danger to others except that commitment cannot exceed the maximum possible penal sentence for any offense charged for which he was acquitted by reason of insanity.

Insanity examinations in the forensic hospitals are generally conducted in conjunction with competency evaluations, and, therefore, it is difficult to determine the number of insanity defense evaluations per year. Western State Hospital identifies 428 individuals admitted for competency and/or insanity evaluations in 1982; Eastern State Hospital lists 168 admissions for examination of competency and 149 insanity examinations.

During the current session the legislature is considering revisions to the insanity defense law. Suggested revisions include a guilty but mentally ill statute as well as stricter requirements for any kind of release or leave with emphasis on notification of all law enforcement agencies when an offender is released.

Community Programs

Community examinations for competency or NGRI may be conducted by private practice professionals or by mental health centers. Local mental health centers and private practitioners may also provide treatment for offenders as an alternative to inpatient treatment or as a follow-up to inpatient treatment. No figures are available on the proportion of offenders evaluated and treated in the community. The forensic hospitals take responsibility for follow-up and outpatient treatment for offenders conditionally released until they are discharged from the hospital. Offenders may be placed in congregate care facilities or adult foster homes at the time of release and are generally supervised and followed by treatment staff of the forensic unit of Western State Hospital and only occasionally are referred to the state probation and parole agency.

Prison Programs

Mental health services are provided in Washington prisons, but no information is available on the number of inmates served or the types of services provided.

Most Significant Current Problems

1. Premature requests for release by patients or their attorneys.
2. Lack of knowledge about treatment programs by courts and community.
3. Shortage of qualified personnel.

Forensic Hospital

The state hospital in Wyoming and its forensic unit is administered by the Board of Charities and Reform, a constitutionally authorized board with responsibility for all mental health, retardation, and correctional institutions in the state. In Wyoming, community mental health services and inpatient state hospital services are administered by different state agencies.

Forensic services are divided into two units, maximum security and medium security. The primary function of the maximum security unit is to evaluate offenders regarding competency to stand trial and NGRI, and little treatment is provided on that unit. Patients undergoing evaluation on that unit are not considered to be patients of the state hospital. Most are kept in cells and returned to the court as soon as possible.

The medium security unit does provide treatment. A large proportion of offenders on this unit suffer from drug and alcohol abuse problems. Offenders who are not dangerous, particularly women offenders, are often placed on other wards in the hospital according to their treatment needs.

Court Evaluations

Almost all evaluations ordered by the court for competence to stand trial or insanity defense are conducted at the state hospital. Sixty-three evaluations for NGRI or competency (both are evaluated at the same time), seven evaluations of prison transfers, nine evaluations of juveniles, and twenty-two evaluations of sexual offenders were conducted during fiscal 1982. Evaluations are done by a separate psychological services unit, composed of psychiatrists, psychologists, and other professionals, who conduct diagnostic evaluations for all patients admitted to the state hospital. Therefore, the staffing pattern at the forensic units does not include professionals involved in evaluations.

Competency to Stand Trial

The court generally gives the hospital thirty days to evaluate an offender. If during that time or at the conclusion of evaluation the offender is in need of treatment the hospital must seek permission from the court in order to treat. Offenders may be kept up to ninety days to receive treatment to become fit to stand trial. If unfitness continues beyond that date, permission must be secured from the court for further treatment. In most cases, the offender is released after sixty to ninety days and returned to court, which either drops charges or, if the person continues to be mentally ill, civilly commits the patients or secures his voluntary cooperation for treatment. If the offender is fit to stand trial at that time, the court determines guilt or innocence. If guilty, the client moves into the corrections system.

Persons committed as "unfit to proceed" may be held indefinitely. However, reports must be made to the court every ninety days on their progress.

Insanity Defense

The Wyoming NGRI law uses the ALI criteria for insanity and places the burden on the prosecution to prove sanity once the NGRI plea is made. In fiscal 1981, the NGRI plea was raised by eighty-three offenders; only one was successful. In fiscal 1982, there were three successful pleas out of sixty-three evaluated. Persons found NGRI who are dangerous may be committed to the state hospital; released under supervision of a state, county, or local agency; or, if not dangerous or in need of treatment, discharged from custody. Persons committed as NGRI receive the same treatment and protections as civilly committed patients.

Community Programs

There is no formal provision for conditional release to the community. Generally, patients are discharged from the hospital, and if charges are still outstanding, they come under the supervision of the parole or probation office. If no charges are outstanding and the patient continues to need treatment, the hospital will try to arrange voluntary treatment at a community mental health center.

Prison Programs

The psychiatrist on the forensic unit also serves the prison and generally makes the determination as to whether an offender should be treated at the prison or at the state hospital. Most offenders going from the prison to the state hospital do so after they are paroled from prison and seek treatment of alcohol abuse and possibly mental illness. Approximately sixty prisoners are transferred from the prison to the state hospital either during incarceration or at the time of parole. Mental health services at the prison are limited but do include providing and monitoring medication by the forensic unit psychiatrist.

Most Significant Current Problems

1. Overcrowding. Due to a continuing increase in the census at the forensic hospital, another sixty beds are needed to meet the demand, primarily for penal code evaluations. The increase seems to be due to courts and defense attorneys taking advantage of NGRI and unfit to proceed options in the law.

2. Lack of staff. There are too few staff members to deal with the number of MIOs in the forensic unit, and they are under pressure to move evaluations along faster because of waiting lists for evaluation.

3. The need to involve mental health centers more in evaluations, particularly of sex offenders which often do not need state hospital evaluation. Evaluations conducted at the state hospital generally find sex offenders are not mentally ill, and most are sent to the prison system.

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LETTER SENT WITH FORENSIC QUESTIONNAIRE

At the WICHE Conference on the Mentally Ill Offender held in Albuquerque March 22-23, 1982, *participants asked WICHE to gather some information about the different systems for handling MIOs in the western states in order that they might be able to assess whether or not programs or ways of handling offenders which have been effective in one state could fit into their own state system.* In trying to develop a questionnaire (and trying it out on a couple of states) we have found that the number of questions and the variations among state systems are so large that such an all-inclusive study would be unnecessarily burdensome to the states and might not provide comparable information.

Therefore, we are suggesting

1) That we confine the study initially to gather information on forensic hospitals with a few questions about alternatives to forensic hospitals that have been developed in the individual states;

2) That we attempt to secure from each state, copies of the basic laws relating to NGRI or its alternatives and incompetency;

3) That while the questionnaire will be sent to the states in advance, the survey *will be done by telephone so respondents will not have to go into great detail on the form.* A telephone survey will allow us to get as clear a picture of the system and its many variations as possible.

WICHE plans to compile the data in narrative and tabular form and will include it and the revised proceedings in a publication.

We suggest that answers to questions 1 through 6 be compiled in advance of our telephone survey and either sent to us or provided over the phone. Other questions may be easier to clarify and respond to during the telephone survey.

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We realize you have been asked to respond to other questionnaires regarding MIOs in recent years, including NASMHPD and Westat, Inc. We have contacted them regarding using their data rather than conducting another survey, but it is not available by state for the western states. *We hope you will feel that information from the thirteen WICHE states will be of sufficient value to you to be willing to fill out yet another questionnaire or respond by telephone.*

We plan to conduct the telephone survey between February 16 and March 11. We are looking forward to the opportunity to discuss these matters with you.

Sincerely,

Meredith Davis, ACSW
Director
Mental Health and Human Services

Enclosure

Questionnaire

FORENSIC HOSPITALS IN WESTERN STATES

1. Do you have a forensic hospital or forensic unit in your state hospital? ___Yes ___No

   If yes, which? _____

2. Who administers the forensic hospital/unit?

   ___State mental health agency ___Corrections agency

   ___Other (specify) _____

3. Is the forensic hospital/forensic unit divided into subunits? (e.g., maximum security, medium security, evaluation, treatment, etc.)? ___Yes ___No

   If yes, please specify the subunits. _____

4. Please answer the following questions for the subunits if information is available by subunit. Otherwise for the forensic hospital/unit as a whole.

Subunit Name	Unit	Unit	Unit	Unit	Forensic Hosp. Forensic Unit
What is the bed capacity?					
What is the current average daily census?					
Current annual budget (amount)					

Please indicate the types of costs which are contracted in this budget (e.g., personnel, equipment, supplies, food service, grounds)

Does this budget include a portion of the overall hospital administrative costs? ___Yes ___No

Rev.1/83

5. Number of annual admissions and average daily attendance for different types of clients admitted to the forensic hospital/unit.

	*No. of annual admissions	**Average daily attendance or daily census
Evaluation only		
a. Individuals to be evaluated for competency.		
b. Individuals to be evaluated for NGRI or GBMI plea.		
c. Convicted offenders referred for pre-sentence evaluation.		
d. Transfers from prison for evaluation.		
e. Other evaluations (specify) _____		
_____		
Treatment		
f. Individuals undergoing treatment to restore competency.		
g. Individuals found NGRI.		
h. Individuals found Guilty But Mentally Ill.		
i. Transfers from prison for treatment.		
j. Transfers from other institutions for treatment (specify institutions)		
_____		
k. Sexual offenders (committed by statute? transferred from prison? other?) Specify.		
_____		
_____		
l. Transfers of civilly committed or voluntary patients from other hospital units who need secure setting.		
m. Other (specify) _____		
_____		

*What are dates of the year used in compiling number of annual admissions?_____

**How was "average daily attendance" determined? _____ Census on one day?
Date

_____ Average for a month or year?
Dates

6. What is the staffing pattern in FTE's at the forensic hospital/forensic unit? If divided into subunits, please indicate the staffing pattern by subunit.

Unit Name	Unit	Unit	Unit	Total Forensic
Number of FTE's				
Ph.D. Psychologists				
M.A. Psychologists				
M.S.W. Social Workers				
M.A. Psychiatric Nurses				
R.N.s				
L.P.N.s				
Psych. Techs. or MH Workers				
Security Guards				
Administrative Personnel				
Support Personnel (clerical, dietary, grounds)				
Other (specify) _____				

7. What types of treatment are provided at the forensic hospital/forensic unit? If divided into subunits and the type of treatment varies across subunits, please specify each subunit separately.

_____

_____

_____

_____

8. Do you have a provision for "conditional release" to the community? ___Yes ___No

What type of client may be "conditionally released (e.g., NGRI, incompetent)?

_____

Who can authorize conditional release? _____

What agency provides supervision after release? _____

What agency provides treatment if indicated? _____

The following questions briefly address alternatives to hospitalization at forensic hospital. You may wish to answer these questions during the telephone survey, rather than in writing.

9. Does your state provide for community evaluation of individual's competency to stand trial? ___Yes ___No If yes, who provides evaluation? _____ _____ Where? _____

10. Please estimate what percent of incompetency evaluations are provided--

In the community? _____%

In the forensic hospitals? _____%

11. Does your state provide community treatment to restore competency? ___Yes ___No

If yes, where? _____

Please estimate percent of individuals receiving treatment--

In the community _____%

In the forensic hospital _____%

12. Does your state provide for community evaluation of individuals pleading NGRI or GBMI? ___Yes ___No

If yes, who provides evaluation? _____

Where? _____

Please estimate percent of evaluations provided--

In the community _____%

In the forensic hospital _____%

13. Does your state provide community treatment for NGRI/GBMI? ___Yes ___No

If yes, who provides treatment? _____

Where? _____

Please estimate percent of NGRI/GBMI individuals receiving treatment--

In the community _____%

In the forensic hospital _____%

14. Do you have mental health programs or professionals at your prison? ___Yes ___No

If yes, what services are provided? (e.g., evaluation, provision or monitoring of medication, therapy) _____

_____

Approximately how many prisoners are served per year? _____

15. Please list any other "alternative" programs which have affected or may affect the census at the forensic hospital/unit. _____

_____

_____

What other factors have affected or may affect the census at the forensic hopsital/unit? _____

_____

The following questions/requests are general ones. You may wish to answer these questions during the telephone survey rather than in writing.

16. Please send us a copy of your NGRI or GBMI (or both) statutes; statute relating to determining competency; civil commitment statute; any other statute particularly relevant to your MIO system.

17. What are the three most significant (troublesome) problems in dealing with MIOs in your state at this time?

_____

_____

_____

18. What kinds of reactions (problems), if any, are the legislature, governor, or public having as a result of the Hinckley decision? Is legislation or other action being proposed? Is there any information from other states that would help in dealing with this?

_____

_____

_____

19. Is there interest in your state in having a regional (13 western states) conference on the MIO this year? ___Yes ___No

If so, on what topics? _____

Who should the audience be? (Types) _____

_____

How many proposed participants do you estimate could get funding (and permission) to attend from your state? _____

20. What information from other states would be helpful to your programs?

_____

21. Any other comments? _____

Thank you very much for the information you have provided. WICHE will be compiling the information from all the WICHE states and will include the information in a publication. You will receive a complimentary copy as soon as the publication is available.